CONTENTS

VOLUME 2 NUMBER 3 JULY 1957

Editor's Page

IN THIS ISSUE of the journal we are printing papers on two major questions of social policy which are of great significance to us, but which are also controversial, namely, segregation and the cultural-religious focus in social work in its institutionalized forms. It is part of editorial policy to print from time to time articles which should stimulate strong reactions, and, whenever feasible, showing divergent viewpoints.

There is a basic value system for social work which is, in a broad sense, axiomatic —which must be taken for granted. Among our axiomatic values, self-evident and universally accepted, are the constitutional guarantees: civil rights and liberties, "the Four Freedoms," human needs and rights, the worth of the individual, mutual responsibility of the individual and his society. Religion and morality are also axiomatic in human interaction, and are a necessity for ethical professional practice.

But granting these assumptions by which we are committed not to remain neutral, but as scientists to remain "on the side of man," there are many differences among us as to how values may be reconciled, complement each other, be implemented. It is hard always for practitioners when they leave the worker-client focus to approach conflicting professional opinions without anger; to be willing to stand up and be counted or, even harder, to make constructive compromises when advisable. One cannot affect social policy without sure footing in a value system and in professional principles. Nevertheless, participation in policy formation at home or abroad does require the discipline to give and take, does call for tough-mindedness as well as flexibility, which may permit concession and mutual modification because ideas should not, and perhaps cannot, be imposed.

One of the dominant interests of today is how to make the contribution of social work, its special angle of vision, more effective in social policy. Social workers will increasingly be called upon to say what are the qualities, substantive knowledge, and skills called for to make us effective in the area of social change. There is general agreement that social policy is a responsibility of the total field of practice as well as of the professional curriculum. Like the value system, it is a permeating subject. All professional functions should have as component those implications which should make a contribution to the formulation and modification of social policies. Conceptualization, data analysis, synthesis, and interaction, among the various services and programs, should be pitched to create a disciplined way of thinking in matters of social policy, its formulation, implementation, and modification. One of the new and exciting dimensions in the practice of social work derives from cultural and sociological phenomena that throw light on factors of class and mobility; discrepancies between aspirations toward culturally approved goals and the feasibility of their achievement—all of which influence personality and relationship. These new insights must be assimilated, tested, and retested.

As we have said elsewhere: "Too often in education, research, social science, and social action, process is unrelated to human feelings and human existence. Social workers must take more leadership in constructing welfare platforms and programs; they must re-commit themselves to manipulating the social as well as the individual environment; but they must also increasingly bring what they know of human behavior and interpersonal adaptations into the fabric of welfare and community life. . . . If we can further knowledge and practice in the field of social as well as psychological dynamics, we can hold up our heads as the oldest, the newest, the most difficult, and the most radical of the professions." [1]

G. H.

[1] Gordon Hamilton, "The Role of Social Casework in Social Policy," *Social Casework*, Vol. 33, No. 8 (October 1952), p. 324.

BY FLORENCE SYTZ

Desegregation: One View from the Deep South

DESEGREGATION CAN BE viewed as a legal, social, economic, psychological, moral, political, historical issue,[1] or its subject matter can be conceived of as today's chapter in man's eternal striving toward that city to which each of us must travel on foot not losing sight of,

> the hard core, which is, do this, do that, love your friends and like your neighbors, be just, be extravagantly generous, be honest, be tolerant, have courage, have compassion, use your wits and your imagination, understand the world you live in and be on terms with it, don't dramatize and dream and escape.[2]

Each of us will need to find his own way toward that city in which individuals are accepted for what they are rather than for who they happen to be by reason of their skin color, sex, money, place of birth, parents, and similar irrelevancies. Desegregation is but one of the villages we will eventually pass through on our way.

However, we who live and work in one of the eight states[3] in the South that as of May 1956 not only had not desegregated any of its public elementary or secondary schools but had passed legislation designed to retain segregation may find our view of

FLORENCE SYTZ, M.S.S., *is professor of social casework at the Tulane University School of Social Work in New Orleans. She has lived and worked in the South for many years.*

[1] For illustrations, *see* the publications of the Southern Regional Council, Atlanta, Georgia, particularly *What the Supreme Court Said* and *Three Views of the Segregation Decisions;* Harry S. Ashmore, *The Negro and the Schools* (Chapel Hill: The University of North Carolina Press, 1954); Gordon W. Allport, *The Nature of Prejudice* (Cambridge: Addison-Wesley Publishing Company, 1954); Eli Ginzberg and associates, *The Negro Potential* (New York: Columbia University Press, 1956); Committee on Social Issues, *Psychiatric Aspects of School Desegregation* (New York: Group for the Advancement of Psychiatry, 1957); Robert Penn Warren, *Segregation, the Inner Conflict in the South* (New York: Random House, 1956); Frederick B. Routh and Paul Anthony, "Southern Resistance Forces," *Phylon* (First Quarter 1957); C. Vann Woodward, *The Strange Career of Jim Crow* (New York: Oxford University Press, 1955).

[2] Rose Macaulay, *The Towers of Trebizond* (New York: Farrar, Straus and Cudahy, 1957), pp. 274–275. *See also,* Lillian Smith, *The Journey* (Cleveland and New York: The World Publishing Company, 1954).

[3] Alabama, Florida, Georgia, Louisiana, Mississippi, Virginia, and North and South Carolina.

the situation becoming skewed. Social work can be threatened from within as well as from without. The clue to wisdom in understanding the present is to be found not only in the past but in our determination not to use outer happenings to turn the mirror away from ourselves. It is so easy for all of us to blame the Supreme Court, the "meddling Yankees," the National Association for the Advancement of Colored People, the Citizens' Councils, the members of the legislature, for our own apathy and fear. It is easy to say that *if* the Supreme Court of the United States had but followed its own separate but equal doctrine which it enunciated in 1896 in the case of *Plessy v. Ferguson,* the progress in race relations noted in 1947 by Charles Johnson and his associates[4] would have continued smoothly and without disruption; or to repeat the *thinking of the last century* voiced by William Graham Sumner ("Stateways cannot change folkways") when we say "You cannot legislate against prejudice." However, when we say these things, we forget that the progress documented by Johnson was made through compromising our democratic and religious principles as well as through often violating in practice (by both whites and Negroes) the custom of segregation while at the same time helping to maintain the "ritual of public homage to segregation."

Prior to the Supreme Court's 1954 decision, gains were made in the South within the framework of segregation largely through not disturbing the "ritual of public homage to segregation," since white southerners were not disturbed by violations of the principle if these were not given wide publicity and if the people requesting the violations were so-called "respectable citizens." For example, permission in the past to use the Municipal Auditorium in New Orleans for an unsegregated meeting might be obtained by one group of citizens, but similar permission might not be granted to another group of citizens in the community.

However, these special privileges and unnoticed violations of traditional southern custom did have the effect of eroding the pattern of segregation to the extent that it became common throughout the South to find patterns of segregation rather than one hard immovable over-all pattern. The gains resulting from this erosion were to be found then, as they still are today, in the extension of opportunities for *all* the people living in our region. Through the efforts of some of the people in southern communities, Negroes as well as whites gained, for example, better job and health opportunities as well as chances to be better fed, housed, and educated. Many of us were slowly, through hard trying, engaged in making our separate facilities at times less separate and always a bit more equal.

No doubt there were people in our communities and in our profession who contributed their share of hard trying to extend opportunities with little, if any, disturbance of conscience as long as the Supreme Court sanctioned the compulsory separation of the races. Others, such as I, worked within the segregation framework even though we did not agree with it. We were heartened by the gains we helped to bring about. For example, by 1950, of the professional associations in the South, Negro "lawyers were admitted in six states, doctors in one, nurses in eight, librarians in six and social workers in all."[5] Academic associations and social welfare organizations both admitted Negro members and made efforts to accommodate them at their meetings. On the other hand, we were often disheartened by the fact that, time and again, we saw how the gains made within the framework of segregation were only exceptions, not gains that established any principle or precedent in behalf of desegregation. That principle in the *legal*

[4] *Into the Main Stream, A Survey of Best Practices in Race Relations in the South* (Chapel Hill: The University of North Carolina Press, 1947).

[5] Woodward, *op. cit.*, pp. 143–144.

sense has now been stated by the United States Supreme Court. This, from my point of view, is real progress.

When the Supreme Court in 1896 upheld the Louisiana statute providing for separate accommodations for the white and colored races, Justice John Marshall Harlan, a Kentucky unionist, dissented. In his dissenting opinion, he stated "Our Constitution is color-blind" and fifty-eight years later, on May 17, 1954, the Supreme Court may be said to have agreed with him and with Justice Holmes who, in 1905, in one of his dissenting opinions, stated, "The Fourteenth Amendment does not enact Mr. Herbert Spencer's *Social Statics.*" The Supreme Court's willingness to reverse in 1954 its 1896 decision is, among other things, recognition of the extent of social change that has occurred during these years. Since it is easier for us to change our methods of transportation from the horse and buggy to the automobile and jet plane than to change our ideas and feelings, it should not surprise anyone today to find resistance in the deep South to the Supreme Court's decision.

It should also not be too surprising to hear the re-echo of the thinking of the last century to the effect that "You cannot legislate against prejudice." Those who say this have forgotten that it was the Jim Crow laws in the South that in large measure created southern folkways and that recent Fair Employment Practices legislation in certain states has created new folkways in factories and in department stores. Furthermore, as Allport points out, legislation does not aim at controlling prejudice but at controlling only its open expression. But when the open expression of prejudice is controlled, changes are more likely to occur in the thoughts and feelings of individuals.

Those southerners who were *not* surprised by the 1954 decision of the Supreme Court had noted in 1935 the decision in the case of *Donald Murray* as well as the decisions in the *Gaines* case in 1938, the *Sipuel* case in 1946, and the Supreme Court decision in the case of *Sweatt v. Painter* in 1950. They were aware of the regional program the southern states had set up for higher education by agreeing to co-operate in the establishment of centers of graduate and professional education that would enroll students of both races from the participating states. The plan makes sense in a poor section of the country because it seeks to avoid the establishment of costly graduate and professional programs in universities in each southern state. Opponents of the plan maintained that it was only a device to retain segregation at the university level until the Southern Regional Education Board intervened, in a case involving the University of Maryland, in order to say, "It is not the Board's purpose that the regional program shall serve any state as legal defense for avoiding responsibilities under the existing state and federal laws and court decisions." By 1953, only five state university doors remained closed to Negroes—those in Alabama, Florida, Georgia, Mississippi, and South Carolina.

In the postwar school cases brought before the courts it became increasingly evident that if the biracial school system were to survive, "equality" would have to be a fact rather than a token. The southern states appropriated additional funds for equalization purposes but these funds continued insufficient to meet the needs of the increasing numbers of children of school age. The activity was all too little and too late. By 1950, Louisiana, for example, was spending 112.8 million dollars on its schools or 4 percent of its income, while New York was spending 610.7 million on its educational program or 2.2 percent of its income. During 1940–1950, the average daily attendance in southern schools increased by 218,000 while there was virtually no net gain in the rest of the country.

DILEMMA OF THE SOCIAL WORKER

Today, the social worker in the South as well as the teacher of social work in any

southern university is sharply faced with the conflict between his personal-professional principles and the purposes of the communities which are often reflected in some social agency board members and university trustees. Many of these board members and trustees are also in conflict since they, as well as we, are law-abiding citizens respecting all duly established legislative, executive, and judicial authority whether at local, state, or federal levels of government. Obedience to this authority when it violates no moral, religious, or professional principle is commonplace enough and causes us no personal conflict. However, with respect to desegregation, many of us are in conflict because our state legislatures have enacted laws designed to retain the traditional custom of segregation and the Citizens' Councils are selecting as special targets for their social and economic pressure teachers, social workers, ministers, and "liberals" whom they often try to link with communism or so-called "front organizations." The present cloud over the "liberal" white citizen in the South is one produced by conflict and fear.

Finding himself in this situation, what is a person to do? In what way can he best fulfill his various obligations? These are the same questions Iredell Jenkins asks in his article, "Segregation and the Professor," [6] and the alternatives he presents are open to us, too, namely:

1. Any one of us can resign from any social work or teaching position we now have—"resign either with quiet dignity or with a ringing public declaration"—without much, if any, personal risk as there are many positions open and available in other parts of the United States.

2. Any one of us can make his views known: to state his ideas in public, to stand up and be counted on this issue. The inner demand that we do this is not so much a demand that we exercise an abstract right but a demand in behalf of our own self-respect and what is conceived to be our professional obligation.

3. Any one of us can ignore the problem through cultivating his own garden, overlooking those portions of it labeled "community organization" and "social action."

4. Any one of us can seek and find, as we often have done in the past, some middle course between resignation and acquiescence.

Those who suggest that we resign or who tell others not to seek positions in the South at this time are forgetting that

> The place to fight for a principle is where it is a living issue, not where it is an accomplished fact, and still less where it has become a mere object of sanctimonious self-congratulation. An individual who resigns inevitably weakens both the cause and the institution to which he is committed.[7]

Our knowledge of the slow progress of desegregation in many parts of the North, despite a tradition and "public policy" as old although different from that of the South, gives us little reason to believe that the deep South, after it accepts the legal principle, will not search for and find ways of softening this acceptance. How long the present transition period will last can only be stated by those who possess a crystal ball. We do know, however, that both the length of the transition period as well as the time it will take to achieve *de facto* desegregation are dependent upon the human efforts of both whites and Negroes. And many of us want to be in the South in order to contribute our share of the human effort to bring about *de facto* desegregation.

Those who suggest that we stand up and be counted on this issue have their own interpretation of and ways of "standing up." Some would not bother to choose the time, the place, the group with which to stand or any concrete specific aspect of the

[6] *Bulletin of the American Association of University Professors* (Spring 1957), pp. 10–18.

[7] *Ibid.*, p. 12.

issue; others would be concerned about all these things plus such factors as preparation, planning, and strategy. The former often appear to be more concerned with having everyone know that they are on the side of right and justice rather than in helping toward constructive, less personally spectacular, achievements.

Those among us who would apparently ignore the issue by advocating the cultivation of our own limited social work or teaching garden maintain that the desegregation issue will be settled by the courts, and quote Georgia's Attorney General, Eugene Cook, who said, in reference to the segregation laws passed by the 1956 Georgia General Assembly, "We might as well be candid. Most of these laws will be stricken down by the courts in due course."[8] This is not the time, they say, for us to intrude and to risk martyrdom since, if we do, we will direct the attention of the Citizens' Councils not only to us but to our social work organizations or educational institutions. We know that whatever we say or do may bring the impact from those who are vehemently opposed upon our profession, our social agencies, our universities—not merely upon ourselves. This is the hard core of the present dilemma of the social worker or teacher of social work in the deep South.

THE MIDDLE COURSE

As I conceive of the middle course, it is a way of proceeding that lies between resignation, martyrdom, and acquiescence. Those taking the middle course will not fail to stand up and be counted but they will choose the time, the place, and the group with which to stand, and they will also be concerned about the preparation, planning, and strategy appropriate to any given concrete aspect of the desegregation issue. They will be aware that there are many different roads to any given goal and that they may choose the wrong one and suffer the consequences.

During a transition period in which social work values are threatened even more severely than they have been in the past, the maintenance of these values demands that we re-examine their significance for social work education, administration, and practice; that we re-examine also the means we can use, not only to achieve them in certain of our professional and educational activities but to retain or to recapture them. Only those who choose the middle course will be stimulated to do this.

Those of us who have lived and worked in the South prior to the Supreme Court's 1954 decision know that there exists in our region a column of decency of which our northern colleagues may not be fully aware because of the noise created by the Citizens' Councils. This column of decency is represented by those who are participating in the work of organizations and institutions such as the local chapters of the National Association of Social Workers, the Urban League, the Southern Regional Council and its state-affiliated organizations, the Commission on Human Rights of the Catholic Committee of the South, the Anti-Defamation League of B'nai B'rith, the National Association for the Advancement of Colored People, and the Jewish, Catholic, and Protestant churches.[9] The position taken by the Catholic Archbishop of the Archdiocese of New Orleans and the ensuing controversy have been widely commented on in northern and southern newspapers. Less widely noted was the conference held recently in which representatives of the National Council of Churches and the profession of social work reached agreement upon a policy statement which calls on the Protestant churches to "encourage

[8] Florence B. Irving, "Segregation Legislation in the South," *New South* (February 1957), p. 8.

[9] For amplification, *see* John Hope II, "Trends in Patterns of Race Relations in the South Since May 17, 1954," *Phylon* (Second Quarter 1956), pp. 103–118.

their members to work for better schools and better housing; to help overcome racial discrimination and to take social and political action to influence community decisions." [10]

In the 1956 session of the Louisiana legislature, the proponents of segregation obtained the adoption (without a dissenting vote) of thirteen measures designed to maintain the compulsory separation of the races in a variety of contexts. Interestingly enough, Act 579 which prohibits mixed participation in "any dancing, social functions, entertainments, athletic training, games and sports" *exempts* religious gatherings, services, and functions. Social workers along with many other men and women of intelligence and good will can work together on some aspect of the desegregation issue if they choose to do so. Increasingly, organizations like those mentioned will need any expertness social workers and social scientists can provide for use in concrete situations.

CONCLUSION

Although it is evident that I prefer the middle course and would find it difficult to sympathize with those who would either seek martyrdom or would run away by resigning or ignoring the problem, I know that, given the conflict, it is inevitable that social workers and teachers of social work will resolve it in different ways. I can only hope that this brief and incomplete statement of the desegregation issue will stimulate others to explore it further and to share with the rest of us their ideas as to ways we can take to resolve our dilemma. I would, however, along with Iredell Jenkins remind them, "That while it is quite easy to say what is right under hypothetical conditions, it is extremely difficult to decide what is best in actual circumstances." [11]

[10] *The New York Times* (May 9, 1957), p. 23.

[11] Jenkins, *op. cit.*, p. 18.

Prevention and Cure

ANOTHER COMMON MISTAKE made by those who write upon social questions in these days is to assume that "cure" and "prevention" are opposed to one another, and that prevention cannot get its just due until we spend less time in curing the ills of individuals. Never was there a more mischievous social fallacy! Prevention and cure must go hand in hand. . . .

From *The Good Neighbor* (1907) by Mary Richmond

BY NELSON C. JACKSON

Building Community Understanding of Racial Problems

BUILDING COMMUNITY UNDERSTANDING of racial problems and their amelioration is currently one of social work's most perplexing tasks. It is a chore that should be done, but is often shirked; a problem tickled but not tackled; an obligation assumed, but not fulfilled. This presentation will examine some of the current community pressures affecting social agencies, the effect of those pressures, and what social agencies might do in this field.

The present crisis in human relations is magnified because some southern states are resisting the Supreme Court decision desegregating public schools. The Supreme Court decision of May 17, 1954, held that Negroes barred by statute from attending public schools with white students were deprived of equal protection of the law, as guaranteed by the Fourteenth Amendment. The court handed down its implementation decree on May 31, 1955. Subsequently, on November 7, 1955, the Supreme Court banned racial segregation in publicly financed parks, playgrounds, and golf courses, and on November 25, 1955, the Interstate Commerce Commission ruled that the segregation of races on interstate trains, buses, and in waiting rooms was unlawful.[1]

The first White Citizens' Council was formed in Indianola, Mississippi, to maintain segregation following the decision of the court, and the movement spread. Councils were originally composed of the "best" people, dedicated to the maintenance of peace, good order . . . and the preservation of states' rights. According to Harold Fleming, twenty prosegregation groups have appeared on the southern scene.[2] The number has increased since his article was published. This condition follows each period of crisis in the South, and has been in vogue since the Civil War.

One group, called Project Big Four, has as its avowed purpose the removal of the tax-exempt status of four national organizations. The group has been organized in California and plans have been under way to form a coalition between the White Citizens' Councils and the interests of Project Big Four in maintaining and furthering segregation.

It should be pointed out at this juncture that in spite of the unlawful action in the disobedience of the Supreme Court ruling, hundreds of communities in the South are obeying the court's decision, and a great deal of what is noted in the press is the action in the hard-core states that are opposed to desegregation. At the same time, it should be understood that in this dilemma the South can no longer be mentioned as being "solid," but is divided ideologically into several parts. Emory O. Jackson, editor of the *Birmingham World*, says they are (1) the slowly changing South with new leadership; (2) the violently resisting South; and (3) the silent South.

We hear a great deal about the latter two concepts. Two ideas are apparent, however; the first, that the bitter attacks against some social agencies are reprisals against them for holding a basic philosophy which

NELSON C. JACKSON, M.S.W., *is associate director of the National Urban League. His article was an address presented to the National Conference on Social Welfare in Philadelphia, Pennsylvania, in May of this year.*

[1] *The New York Times* (March 13, 1956).

[2] Harold C. Fleming, "Resistance Movements and Racial Desegregation," *The Annals of the American Academy of Political and Social Science*, Vol. 304 (March 1956), p. 44.

has not changed since their organization, but now becomes dangerous to the *status quo* because of the court rulings; and the second, that social work, as it seeks to improve the individual, group, or community, is obligated to work toward remedial change.

The implications of actions taken by social work agencies cannot be limited to one section of the United States, nor have the attacks been limited to one region.

PRESSURES AGAINST SOCIAL AGENCIES

During the past three years, increasing pressures have been applied to some agencies in the group work-recreation field, to welfare councils, and to Urban League-community chest relationships. In each instance the attacks have occurred because local White Citizens' Councils, or similar groups, felt that the work of the social agency ran counter to the maintenance of segregation. There are four elements which affect conditions under which social agencies currently operate. They are:

1. The passage of segregation laws. The *Southern School News* reports on March 10, 1957, that 120 state segregation laws have been enacted since May 1954.

2. Prosegregation reporting in some newspapers, and the use of materials developed outside the South and sent in.

3. The importation of the prosegregation leaders to southern communities about to desegregate schools, and

4. The intimidation of businesses and leaders who might be inclined to disagree with the segregationists, or who have supported national agencies.

A brief review of the effects of some of the recent laws passed by state legislatures to maintain segregation would show that most of them restrict freedom of speech, assembly, and petition. Soon after the passage of one sheaf of state bills by a legislature, the executive of one national agency called to discuss the matter, and stated that the operation of the agency in that state would, of necessity, be severely curtailed under the statutes enacted. It is the opinion of many that it will be impossible for many agencies to operate in a democratic fashion in any of the states passing such legislation until those laws are removed from the statute books.

The use of printed material to attack agencies and ideas demands special treatment because it is in this media that many of the attacks occur. The interesting point is that most of the anti-Negro and anti-Semitic literature which is now flooding the South comes from sections of the North, namely, New York, New Jersey, Missouri, Colorado, and the West Coast, where segregation is not an issue. One publication, the *White Sentinel,* published in St. Louis under the editorship of John W. Hamilton, until his recent conviction and sentence to prison on a sodomy charge, has been responsible for a number of tracts that have been distributed widely. They are violently anti-Negro in character. There is also a four-page sheet called, "Community Chest Supports Race Mixing," which is essentially an attack upon the Urban League. However, very clever articles carried in the *White Sentinel* and in the *White American News Service* suggest that there is also a basic fight on federated financing. In each instance the material prepared for consumption in local communities is replete with innuendoes, half-truths, and lies.

Hunting season, using this material as ammunition, usually starts during the period of preparation for the united fund or community chest campaign, and extends during the campaign. However, the stealthy segregation hunter has paralyzed several campaigns of community chests or united funds by the surprise attack method, particularly where opposition was weak, or panicked.

Also involved in the scurrilous material sent for community consumption are quotations from the House Un-American Activities Committee files which are freely used in the documents sent to local communities.

The House Un-American Activities Committee reports clearly state:

> The public records, files, and publications of this committee contain the following information concerning the subject/individual. This report should not be construed as representing the results of an investigation or findings of this committee. It should be noted that the individual is not necessarily a communist or a communist sympathizer, or a fellow-traveler, unless otherwise indicated.

Yet the material from the House Un-American Activities Committee's file is liberally used for character assassinations in many instances, on some of the flimsiest pretexts. One former chest president in a large southern city was fearful that someone would find out that he gave five dollars to an organization committed to improving southern conditions.

It is significant that in several instances persons who export abusive literature to council groups below the Mason-Dixon line have at one time been affiliated with the Communist Party. One might well question whether divisive forces are now a part of the plan of the Communist Party to divide and conquer by keeping the segregation issue alive, and thus weaken America's prestige at home and abroad. As a case in point, the average taxpayer is having his taxes increased because of the need to spend money in Asia and Africa to win friends and influence people. It costs a great deal of money to convince people who are of darker hue that the pronouncements of democracy mean anything, when the facts of life are evident in the disobedience to the Supreme Court and the attempted destruction of agencies in a democratic society.

A quote from one of the White Citizens' Council papers in the South is an indication of how one of these groups is working to seek the ouster of agencies:

> Our chairman has been untiring in his efforts to determine which of the United Fund agencies are working for racial integration; sponsoring or condoning racial integration, or who participate in racially integrated activities, so that the contributors to the United Fund can be apprized of the facts and then be in a position to demand that such agencies be dropped from the United Fund, or made to follow the principles of segregation, in accordance with the expressed wishes of a vast majority of the people—the supporters of the United Fund.

This same council president, in another letter directed to the president of the board of a group work agency, states:

> The people . . . have rather positively shown, through the action of their duly elected representatives in the Legislature, their determination to maintain separation of the races and, therefore, the Citizens' Council urgently requests the Community Chest to either drop the [name of agency] from its membership and sponsorship, or require this organization to discontinue its teachings and practice of integration of the races.[3]

OUTSIDE PROSEGREGATION LEADERS

Daily newspapers and Citizens' Council releases regularly report the use of members of legislatures and other state and federal officials who come into some of the hard-core states for the purpose of re-emphasizing the need to maintain segregation. In some instances, the pronouncements by officials have been tantamount to suggesting that resistance be continually maintained, even at the expense of bloodshed.

The entrance of John Kasper from Washington, D. C., and Asa Carter from Birmingham, Alabama, as mentioned in the press of a number of cities, caused strife and turmoil in communities where they have attempted to stave off the normal process of school desegregation.

After a 1957 legislative committee of Florida investigated John Kasper, several of the communities where he was scheduled

[3] Citizens' Council of New Orleans *Bulletin* (August 1956). This paper is published occasionally. It is alleged to be in financial difficulty.

to appear refused to have him, not because he was stirring up strife and foment in the community, but because in his earlier life around New York it was proved that he had associated with Negroes. This, therefore, made him unacceptable as a prosegregation exponent. The *Tampa Morning Tribune* of April 12, 1957, announced that Kasper plans to start a segregation paper in that city.

When such outside persons enter local communities with their statements, there is quite often immediate apprehension about possible damage to normal community operations in the seeking of funds for welfare purposes. For example, when the United Fund of Oklahoma City received an ultimatum from the White Citizens' Council in that community, investigation revealed that the resolution presented to the fund had been drafted by one Gordon Hines, who had not appeared at earlier Citizens' Council meetings. He was identified as a ghost writer without assignment, and an unemployed public relations specialist who was known to have incited trouble in the ranks of organized labor and in politics. The police did not have enough evidence to indict him, but stated that they felt he was "making a fast buck."

The question may properly be raised regarding the amount of money now being made by the professional hatemongers who are traveling around the country in the interest of "making a fast buck." It is alleged that the increasing membership rolls of the Ku Klux Klan give evidence that an organization once dormant, and in many states forbidden by law, has now come forth with successful membership campaigns. That there is money in the racket can be noted by the statement made to me by a friend in one southern state who said that he had lost a great deal of respect for one official because he had found that he and his brother were manufacturing Ku Klux Klan uniforms.

Individual leaders have been intimidated in many of the southern states if they dared to stand up for what they believed to be right, if it was contrary to the segregation point of view. In extreme instances they have had to leave the community and seek their fortunes elsewhere. Some, however, have stayed to fight the battle which they felt was necessary for a democratic America.

The *Wall Street Journal* of March 9, 1956, and issues of several national newspapers have indicated that one by-product of the southern desegregation-integration hassle has been the boycott of businesses by White Citizens' Council members with a great deal of instigation by the *White Sentinel* newspaper. The *Wall Street Journal* discussed these boycotts against the Ford Motor Company, Philip Morris cigarettes, Falstaff beer, and a number of other concerns and products. There is constant suggestion in the *White Sentinel,* for example, that use of Ford products helps the desegregation fight. Interestingly enough, industry, in the main, has given these attacks the silent treatment.

Opie L. Shelton, executive vice-president of the Baton Rouge Chamber of Commerce, stated in describing the boycotts that a solution must be found for the present chaos, and that solution must be found by the businessmen. He suggests the necessity for responsible men of both races in every community to get together for consultations and plans.[4]

Labor has been in turmoil in many southern communities and a serious threat has occurred to the organizing drives of AFL-CIO, and even to the retention of unions over the segregation issue. By and large, however, it would be most difficult to establish a southern federation of labor, as is the desire of some of the White Citizens' Council proponents, because it would be difficult to secure a majority membership in any plant. However, it is reported that there is collaboration between proponents

[4] Opie L. Shelton, "Place of the Chamber of Commerce in Education," speech given before the Southern Association of Chamber of Commerce Executives, March 20, 1956.

of the southern federation idea and the right-to-work bills which have been introduced in many legislatures. Labor's dilemma, therefore, is apparent.

Taking cognizance of some ramifications on the southern scene, the AFL-CIO Community Services Committee prepared a statement which was adopted in June 1956 by the Health and Welfare Advisory Council of the AFL-CIO Community Services Committee. That statement reads:

> In keeping with Judeo-Christian tradition and consistent with the moral principles underlying our American society in the field of social welfare, the Advisory Council, AFL-CIO Community Services Committee, recommends the adoption of the following statement of policy in relation to the conduct and financing of health and welfare services.
>
> "Organized labor is opposed to any restriction in the provision of health and welfare services on the basis of race, creed, or color.
>
> "Specifically pressures to restrict inclusion of agencies from Chests and Funds because of issues of race, creed, and color are inconsistent with the principles above enunciated. Cooperative efforts by management, labor, professional and civic leadership should be mobilized to insure the provision of services in accordance with these principles."

Where this resolution has been implemented in local communities, it has been helpful.

It would, of course, be extremely advantageous if the U. S. Chamber of Commerce, or other similar national combines in the business field, would prepare a statement of principles indicating their point of view regarding the integrity of agencies in the field of social welfare similar to what has been done by labor.

Interesting developments are the voices in the wilderness which are lampooning the most violent diatribes of the segregationists. One of these is P. D. East, editor of the *Petal Paper* in Petal, Mississippi, whose pungent writing has ribbed the *status quo*. In an advertisement in one issue he says: "Here's sweet music. Yes, *you*, too, can be superior. Join the glorious Citizens' Klan next Thursday night."

He also suggests in an editorial that since the crawfish is progressive and the magnolia is not, that the progressive crawfish replace the magnolia as the symbol of the state of Mississippi.

Another writer, Harry Golden, editor of the bimonthly *Carolina Israelite*, suggests several ways out of dilemmas. As reported in *Time* magazine of April 1, 1957, his vertical Negro plan suggests that there is no difficulty over segregation so long as the Negro is vertical, and that it is only when he "sits" that the "fur begins to fly"! He suggested providing only desks in all the public schools of the state with no seats. Another suggestion was to put signs on the white fountains in the stores, indicating them to be out of order, and let them be out of order for a year or so, so that everybody would drink out of the colored drinking fountain. The article indicates his key to the plan is to keep the sign up for at least two years. This must be done gradually, he said. Such lampooning, of course, takes the tension out of the effects of pressures.

RESULTS OF PRESSURES

Four results of pressures are noted, as related to financing voluntary agencies through funds and chests:

1. *An ostrich attitude*—if you don't look, it will go away. This condition exists when there is mild or unorganized pressure, but can immediately change when pressure is applied.

2. *Recapitulation* to the forces of terror, believing everything that is said, and the use of reprisals against social agencies which do not forthwith cease to operate with funds coming from community chests and united funds.

3. *The shifting positions.* They usually come in series based upon the ability in the local community to devise ways of main-

taining the *status quo*, and still giving in to pressures. Such ideas can be noted in the request that a local agency change its name and not contribute to its national, or that it disavow in its program emphasis any activity which might suggest consideration of programs which would be integrationist in character. Or that a local group will finance the budget of the agency for a period of a year in order not to cause harm to the other agencies in a united fund.

4. *The forthright counterattack.*

In some communities leadership decided that it would ignore the attacks of local groups, and postseason conferences revealed that if they had taken action earlier, they might have come out better. But their statement was that they did not believe the situation to be important enough to cause any consideration on their part at the time. Their concern was not what damage would be done to social agencies in the community, but "is the battle worth fighting if agencies which are unpopular continue to receive funds?" This might underlie the thinking in several of the categories mentioned above. Thus the damage to what is claimed to be otherwise successful campaigns is laid at the door of one agency.

On the eve of the campaign in Richmond, Virginia, 20,000 copies of the document, "Community Chest Supports Race Mixing," attacking the Urban League, were circulated. The board of the local Urban League met, and in an extremely long session decided to withdraw from the campaign in order not to hurt the other agencies in the campaign family. It is interesting to note that just prior to this event, the local welfare council had recommended the continuance of the agency as a necessary organization.

In Norfolk, Virginia, thousands of copies of this abusive document were circulated prior to the campaign. This city in 1956 gave the National Urban League $361. The national was not included in the campaign after this occurred, but it is interesting to report that for the 1957–58 campaign the local united fund board decided that the National Urban League would not be included, although they found out that the spurious campaign against the organization was sponsored from St. Louis. Paraphrased, it might be apropos to state that, "the operation was a success, but the patient died."

In several instances, a forthright statement of principle was enunciated by the board and staff of a local community chest, even though they realized that there would be difficulties. These campaigns were successful. Oklahoma City might be mentioned as a case in point.

The 1956 annual report of the United Fund of Fort Worth and Tarrant County quotes the following:

> The 1956–57 campaign was an uphill fight from the very beginning. Shortly before kick-off day, our United Fund found itself subject to vicious and unprincipled attack because of an agency included in our group of 45 agencies.
>
> Launched by a hate organization in St. Louis, the attack resulted in some serious loss of money from employee groups, and, to a lesser extent, among management and professional groups. However, the combined losses resulting from this outside effort to discredit the United Fund did not nearly equal the losses sustained due to a strictly local problem.
>
> The following concerns lack of enthusiasm on the part of management. Records indicate that since the first United Fund campaign in 1952, the enthusiasm of management each year has undergone a steady, though slight, decline.

With the rather sordid story that has been told up to this point, it might be well to review the campaign results in selected communities for 1955, 1956, and 1957. The results in 24 cities, which include many southern communities under attack, reveal that there was not a single community in which funds raised in 1957 were below those raised in 1956, and although in some instances they did not make 100 percent of their goal, only in a few places was

the goal less than 100 percent over the previous year. This would imply that despite the fear and the trouble, money is still being raised successfully, and the fund-raiser who says raising money is above principle was concerned primarily with this 100 percent rather than the disturbance which an agency might cause because of its unpopularity in a torn community.

ROLE FOR THE SOCIAL AGENCY

Social work has reached a new crossroad. Early pioneers in the field fearlessly fought for many of the advances the profession now enjoys as routine. The opportunity is again with us to exercise a leadership. This leadership must be instilled in the citizens who support social work. A courage which can stand on principle rather than expediency is basic.

This crossroad is exemplified, also, in the need for contributing to the positive community climate necessary for progress. The social agency has a responsibility to work with other groups for the maintenance of law and order, and the protection of social institutions, including the public school system. Obviously, there can be no development of sound human relationships where there is bitterness and strife.

No doubt this treatise has caused consternation among some members of our group who are accustomed to work under more favorable auspices. There appear, however, several courses which might be considered for action.

1. Lay and professional persons could assess their local conditions by conferences called among themselves. Such conferences could provide a true picture of what agencies need to do in their areas where racial problems exist. The statement of ethics developed by the Welfare Council in Dade County, Florida, suggests the credo covering those agencies and protects them from capricious and unfounded attacks by bigots.

2. Many communities are burdened with increased immigration of nonwhite populations. The movement to the suburbs has accentuated problems in cities. Social planning agencies in some areas are becoming increasingly concerned with such problems as urban renewal and slum clearance. This role should be accepted by social work agencies as having high priority.

Frequently there is little relationship between the social and physical planner. A positive plan, however, is noted in our nation's capital. United Community Services is making plans for a demonstration project in connection with the relocation of some 4,000 families who will be moved from southwest Washington.[5]

3. Agencies could give more attention to the needs of minority populations in all fields of interest. Adoptions for minority children have recently been spotlighted, and where agencies have worked on the problem, increased numbers of adoptions have occurred. There are many places, however, where it is still impossible for a Negro child to grow up in a normal family setting.

Care for the unmarried mother, the mentally and physically handicapped, the delinquent and aged are all influenced by the racial and/or religious factor. And in one city, it was reported that organizations feared to become "Negro" agencies, and thus had a quota of cases which could be given care for this reason.

4. Building community understanding of racial problems will increasingly have to be accepted as a normal function, whether it is liked or not. It will require the highest type of statesmanship, and some leadership should come from national agencies. The idea is best expressed by the united fund director in a southern city who successfully repelled an attack because of a positive stand taken in a racial situation. He said: "If you start running, where do you stop?"

I leave this question with the reader.

[5] Letter from Isadore Seeman, Executive Director, United Community Services, Washington, D. C., February 15, 1957.

BY DON J. HAGER

Religion, Delinquency, and Society

AN INFORMED VIEW of the controversy now taking place in social work circles concerning the role of organized religion in probationary, rehabilitative, and child welfare services must necessarily include reference to certain features of the contemporary religious scene in America: (1) dispute over the meaning and significance of the "new religiousness," (2) increased emphasis on the institutional role of the church in public affairs, (3) popular religion—the ostentatious display and commercial promotion of religious themes, (4) accelerated effort on the part of various sects to influence social policy and to control the appointment or election of public officials, and (5) a marked increase in the social expression of interreligious conflict and controversy, particularly in the fields of public education, government, and welfare services.[1] Each of these factors contributes to the unresolved character and persistence of the current controversy regarding the use of religion in the rehabilitative and probationary process.

Difficulty attends the interpretation of America's postwar "religious revival" because in a "secular" society (at least one in which there is no official church) there is no necessary correlation between a rise in the fortunes of organized religion (buildings, membership, and services) and an increase in religious thought and motivation. In a society where roughly one-half the population achieves goals and satisfactions without reference to traditional religious membership, social distance between the religious and secular worlds persists. Sectarianism and the manipulation of religious sentiment for political purposes tend to cleave communities along religious lines and almost inevitably bring pressures on public institutions and services. Sectarian pressure may be brought to bear on court officials, the confidentiality of court records violated, and the care and disposition of delinquent and neglected children may become involved in a power struggle. Nevertheless, the position for the public services of eligibility not based on race, creed, religion, or color seems unassailable.

THE COURTS AND RELIGIOUS AFFILIATION

Many courts record the religious affiliation of the children and families coming within their jurisdiction; this information is customarily used as a guide for sectarian referral or for foster-home placement, particularly if religious identity between child and foster care is required by statute. Important questions arise, however, when courts go beyond this usage and impute diagnostic significance to the presence or absence of church affiliation on the part of the child or his family.

Courts and social workers themselves may question the meaning of the formally designated religious affiliation for various reasons. Membership may not be a reliable index of religious conviction or way of life. Statistics reporting the presence or absence

DON J. HAGER, Ph.D., *is director of the Commission on Community Interrelations of the American Jewish Congress, and lecturer in sociology at Columbia University.*

[1] For a comprehensive review of the impact of religious and sectarian controversy on public and communal services, *see* Don J. Hager, Charles Y. Glock, and Isidor Chein, eds., "Religious Conflict in the United States," *Journal of Social Issues*, Vol. 13 (December 1956).

of church affiliation among delinquent children and their families are often fragmentary, contradictory, and subject to many discrepancies and deficiencies. Church-affiliated as well as nonaffiliated children commit delinquent and antisocial acts; therefore, even if statistical reports were to show that the rate of commission of affiliated children is substantially lower than that of the nonaffiliated, there are no objective grounds for assuming that the affiliation variable is the determining one. Often, baptism may be the only evidence. Data regarding religious affiliation do not, at this stage of inquiry, warrant unqualified assertions about the delinquency-potential or rehabilitative risk of the affiliated versus the nonaffiliated person.

Courts have also become involved in matters beyond their purview and function regarding positions and actions assumed with respect to recorded affiliation. Some courts observe the practice of automatically transmitting these recorded affiliations to the appropriate clergymen in order to "encourage church attendance by the delinquent and his family" or to "advise *church attendance* where the subject has failed to attend even if *there is no church membership.*" This becomes in effect a requirement. Nonattendance at church is then considered a violation of probation or parole much like nonattendance at school. Note that these particular requirements are markedly different from those involved in sectarian referral and placement. Such practices may not only constitute an infringement of religious liberty for the nonconforming but, in addition, may lend the authority of a public court to sectarian pressures for religious conformity. Thus, the American idea of voluntary entry into and exit from the religious community is violated both in spirit and practice.

MANDATORY RELIGIOUS REQUIREMENTS

Statutes and administrative rulings requiring religious identity between probationer and probation officer, between children and foster-home parents, and between children and adoptive parents are not uncommon. These requirements proceed from the assumption that where there is religious and other social correspondence between child and adult surrogate, adjustment and rehabilitative problems will be reduced. Beyond the fact that such statutes, however commendable their intent and motivation, tend to raise serious constitutional problems, they also introduce an element of religious conformity into the distribution of child welfare services, employment policies, and case assignment practices. In addition, courts have been known to mitigate the intent of sectarian matching by ignoring the "when practicable" clause, thus turning a discretionary factor into an absolute requirement. In many cases, this amounts to arbitrarily assigning a priority to religious membership over all other needs of the child, a practice that may prove harmful to the welfare of children and prevent the accomplishment of the proper purposes of probationary and rehabilitative treatment.

Still other complications may flow from mandatory religious matching requirements. Case assignments and family selections made on the basis of religious matching may also lead to the perpetuation of administratively unsound and inefficient casework practices. These lend credence to the notion that only Protestants can work with Protestants, Catholics with Catholics, and Jews with Jews. Furthermore, the superficial sharing of the same religious affiliation is likely to detract from rather than add to the quality of the relationship between child and adult; in fact, to insist on religious identity (or on any particular identity factor) is to assure or, at least, heighten the possibility of a relationship based only on formal identification.

Finally, there is the questionable validity that attends certain assumptions commonly invoked to sustain identity requirements. For example, do they increase or improve

the quality of the relationship between child and adult as well as the quality and effectiveness of the personal and social rehabilitative services rendered? What evidence is there to show that probationary services, foster-home placements, adoptions, and rehabilitative services are less adequate when religious identity is not found practicable?

There is, for instance, the assumption that a social worker or probation officer "better understands a child of his own religious faith" or that religious identity is necessary in order that the worker may be able to "detect and nurture the spiritual needs of the child."[2] It can be said that there are no professional or theoretical grounds for religious identity assignments in a *public* agency especially since every community provides for the voluntary expression of the religious sentiment. It has not been demonstrated that the lack of religious identity in any way denies or hampers the right to religious nurture. Such requirements are not imposed even in those instances where contact between court and child reaches its most protracted and intensive state—in the clinical, psychiatric, and counseling services. Religious identity requirements and their consequences often tend to plunge the worker into religious and spiritual functions that, as a public officer, he is usually enjoined from performing. Since a public officer has no license to inquire into the "spiritual needs" of children or families, how is he to render a judgment concerning the relevance of religion to the child's behavior or rehabilitation?

The lack of objective validation is the centrally disturbing fact that characterizes many of the assumptions associated with religious identity requirements. This fact becomes more unsettling when considering the recent increase in pressure for the enactment of religious identity *statutes* and for insuring that such requirements be made absolute rather than discretionary in application. In summary, however commendable the values sought by these requirements, it would be an act of negligence to overlook questions relating to their constitutionality, their consequences for children, and for the advancement of social work theory and practice.

The pressure of religious requirements combined with organized sectarian structures and roles often invades courts and serves to reinforce the viewpoint of those judges and court officers who appear to support the practice of requiring church attendance or periodic visits to clergymen as a condition of probation. In an article appearing in the July 1955 issue of the *American Bar Association Journal,* a well-known Chicago jurist, Judge Julius H. Miner, speaks of "the many wayward children *whom I have sentenced to attend* church and Sunday school. . . ." (Italics added.) Beyond the questionable constitutionality of this practice, it appears to equate religious observance with punishment—a tactic that can hardly be said to benefit either religion or the child. The Children's Division of the American Humane Association, in its published booklet (1956), *The Fundamentals of Child Protection,* offers the following observation:

> Disrespect for authority, disregard for property rights of others, immorality, licentiousness, obscenity, profanity, and possibly sexual deviations are highly contagious. . . . This is equally applicable to attitudes toward religion. The parent who does not attend any church or who flouts religion sets a pattern of irreverence for his children to follow.

Insistence on conformity, disregard for the American idea of voluntary acceptance or rejection of religious training, the use of religion as an instrumentality of the *status quo,* and the implication that lack of church attendance is to be equated with "licentiousness," "sexual deviations," and

[2] For a more comprehensive discussion, *see* Don J. Hager, "Racial, Ethnic, and Religious Factors —Their Relationship to Appointment Policies and Casework," *NPPA Journal* (April 1957).

"obscenity" would be questioned by many citizens.

RELIGION AND THE THEORY OF CASEWORK

Imposition of sectarian requirements on public child-care services has serious implications for the theory and practice of social work. There is no body of theory that suggests that such requirements are necessary for diagnosis and treatment even though most would subscribe to the possible importance of religious values in the life of the individual. Religious requirements tend to deny the professional training of social workers by insisting that religious identity should take precedence over the application of social work knowledge and skills in child welfare. Current claims that social service employees should be certified on religious rather than professional qualifications mean, in effect, that demonstrated theoretical and practical social work techniques cannot be put into operation *until* specified religious requirements, often nominal, are honored.

When proposals are made claiming relevance to theories of delinquency, rehabilitation, and treatment, there is always the obligation to submit the empirical base for the claim. One can understand, for example, the relevance of cultural deprivation to low levels of aspiration, or the relevance of family instability to emotional insecurity, although even this is not fully documented. But what is the evidence that nominal religious affiliation reduces the problems of children and their families? At this stage of inquiry, we are not informed by data or empirical generalizations that such factors have been established as therapeutic agents of general applicability; that is, of the same universalist nature as that concerning the relationship which commonly obtains between parental rejection and the antisocial behavior of children. The claim of relevance, actual or unintended, cannot now be validated by legislation, judicial determination, or by importunate assertion.

RELIGION, DEVIANCE, AND THE STATUS QUO

The rise in the number of delinquent and troubled children is a serious problem. But it is hard to avoid the conclusion that many of the measures proposed to manage this problem are dominated by a philosophy of fear, hostility, and conformity. Fear is manifest in many of the desperate and feckless proposals now being offered in the hope that their enactment will "curb" delinquency, *e.g.*, curfews, fining, or other punishment to parents for the antisocial acts of their children. We "fight" or "combat" delinquency; but we tend to shirk assessing the conditions that produce it. Nor do we appear willing to acknowledge the observation that children are labeled "delinquent" only by virtue of age and legal decree. They are, like most of us, people with problems. A little younger, and perhaps, only a little less wise. But the difficulty, of course, lies not with the label but with the assumption that "delinquents" are a species apart, intent on defying the superior wisdom of their progenitors. And yet, delinquency is a *social* phenomenon precisely because it cuts across race, creed, religion, class, and region. And its magnitude creates a social guilt that stands behind the punitive and retaliatory attitude of many American communities.

Perhaps it is unavoidable, but it nevertheless appears that in their institutional aspects, many religious organizations tend to submit to rather than challenge the *status quo*. They are inclined to stress conformity, particularly in the sphere of moral conduct, and to insist on the priority of religious over other sanctions for moral behavior.

Delinquency and crime as forms of deviant behavior are a part of the social process and not merely behavioral aberrations or

"social problems." They are responses to structural and other stresses that are present in American society, *e.g.*, "success" (to some extent, this explains the forces of discontent and frustration that generate delinquent behavior in middle- and upper-class children).

The religious or supernaturalist view of human nature is inclined toward the adoption of moral absolutes, indices of error and waywardness, and devices intended to shape behavior in the direction of preferred standards and goals. As a result, ideas, methods, and programs unrelated to dogmatic precepts and doctrine are often met with doubt that human intelligence and effort can help manage and resolve problems of human life and experience. Accordingly, the social and psychological factors known to contribute to deviant behavior may be de-emphasized or denied proper recognition and the determining element in the rehabilitative process becomes the doctrine of personal culpability and moral deficiency. Religion is one among several sources of sanction that societies may invoke to sustain, control, and perpetuate, socially defined standards of conduct. In a complex modern society, however, a problem arises when any fixed ideological orientation attempts to deny the social validity and influence of other sanctions and institutions.

The adolescent who engages in antisocial behavior because of some unmet social or psychological need is often indulging in a form of rebellion. Religion is often equated with parental authority and the *status quo*. Ignoring the social and psychological individual reactions of the delinquent, sectarian and other surrogates may tend to insist that the delinquent reform and conform; that he be made to acknowledge the "error of his ways." In short, he is being compelled to say that society is "right" and he is "wrong." But the social and psychological complexes that surround adolescence, deviance, and delinquency, and which we are only now beginning to understand, are precisely those factors that make it difficult for the delinquent youth to change his attitudes and behavior on those terms which seem unrelated to his past, his present, or his future. To be told that he is "wrong," "sinful," or that he must conform to specified rules of conduct, offers him no promise, hope, or informed insight.

Youth-serving agencies that concentrate on "good risk" delinquents and turn the "poor risk" or "difficult" cases back to public or other agencies only increase the problem. Almost any well-supported program, public or private, will make some contribution to the rehabilitation of those children who show the highest potential for behavior modification. As the matter now stands, however, the reluctance of certain agencies, both church and nonchurch, to create and sustain program for those children that constitute a formidable challenge to the rehabilitative effort results in turning them back upon already overburdened and often harassed public agencies. Nor is this situation improved by the tactic of those agencies who, while rejecting responsibility for extending their services, strongly oppose the development and expansion of an inclusive public family and child care service for *all* children.

The foregoing observations are not intended to deny the value of religion in giving meaning and purpose to human life. Nor do they question the role that religion plays in the life of particular individuals. Moreover, the remarkable contribution that sectarian agencies have made to the advancement of family and child welfare services is beyond dispute. What is deserving of examination are the various assumptions concerning the relevance of institutional organization of religion to the theory and practice of rehabilitative social work in public agencies. The distinguished Protestant theologian, Reinhold Niebuhr, speaks to this point when he states that:

> It must be admitted that religion is not itself able to provide the detailed

knowledge of human motives and of the intricacies of human personality which is necessary to the most helpful treatment of maladjusted individuals. Religion, except in cases where it is expressed through highly gifted individuals who have an intuitive understanding of human character, does not supply what must be derived from the science of psychotherapy.[3]

It is granted that the pursuit and application of mandatory and other religious requirements in public rehabilitative services reflect the interest and concern of the religious community. On the other hand, interest and concern are not adequate substitutes for validated evidence derived from practice. Sectarian bodies have long been identified with the struggle to promote community responsibility for the care and welfare of children. It would indeed be tragic, therefore, if certain groups should now permit largely sectarian aims to contravene a principle that they have fought so valiantly to establish, namely, that in matters pertaining to the welfare of children, the overriding consideration is to act on behalf of the welfare of each child irrespective of race, religion, ethnic status, social class position, and of the competing demands often imposed by institutional aims and social pressures.

[3] *The Contribution of Religion to Social Work* (New York: Columbia University Press, 1932), p. 65.

The Backbone of Progress

THE BACKBONE OF medical progress is the scientific journal. Books are valuable records of progress, as well as tools of research, but books are not themselves the building blocks of progress, because they become almost obsolete as soon as they are available, so swift is the march of science. Furthermore, the writing of a book is a huge project, not practical for the average worker in the health field. By contrast, the scientific paper is an almost immediate record of a new idea, a swift report of a research project, a springboard for further advance. Even the most humble worker in any branch of health science can make a simple record of an observation, put forward an idea, or register the results of a project. Each of these little contributions may be a minor one. Yet in the aggregate they spell out the story of scientific progress.

. . .

No editor insists on only brand-new, totally fresh ideas. There are very few absolutely original scientific discoveries in a century. What makes a paper valuable is not necessarily an absolute novelty of content. An article is valuable if old material is refiltered through the author's own experience; if existing literature is critically reviewed; if minor tips can be given to fellow workers; or if illustrative cases can be cited. A new twist to an old idea is always welcome. A simpler way of doing things, a new and workable appliance, an efficient method of recording, even a simple report on the way in which standard methods have worked out in practice—all these are grist to the editorial mill. . . .

From *Guide to Medical Writing* by Henry A. Davidson, M.D. (Ronald Press, 1957)

BY JOHN M. MARTIN

Social-Cultural Differences: Barriers in Casework with Delinquents

Is THE EFFECTIVENESS of casework in agencies concerned with delinquency prevention and control reduced because of difference in social class background between caseworkers and the children they seek to help? Do racial, ethnic, and religious group differences between workers and delinquents also reduce casework effectiveness in such agencies? Although direct experimental evidence on the subject has not been scientifically accumulated and analyzed, much of the acceptable theory and fact of social and behavioral science indicates that both questions should be answered in the affirmative. (It should be noted at the outset that despite this paper's concern with the caseworker-child relationship in the social treatment of delinquency, the analysis is perhaps applicable to other social work activities in and outside of the delinquency field.)

Apparently a large proportion of our caseworkers are drawn from middle-class families. For example, a recent study of the social position of a sample of Detroit social workers concludes that, according to such criteria as paternal occupation and economic status, the sample had a predominantly middle-class background.[1]

Most criminologists agree that the majority of our children singled out for attention by delinquency prevention and control agencies are lower-class children. In reference to the activities of the juvenile court, for example, Reckless states in his concept of "categoric risks" that lower-class children are more likely to be reported to courts for their delinquencies than are children from the higher and more influential stations of life.[2]

Caseworkers attempt to establish professional relationships with children and their parents as points of departure for rendering assistance to them. In fact, an effective relationship is considered a *sine qua non* in successful casework treatment. The casework relationship has been defined in many ways, but in essence it is one type of intimate personal relation. Such relations involve, among other things, a minimum of social distance. For the purposes of this paper, social distance is defined as reserve or constraint in social interaction between individuals arising from differences in their group experience. Some social workers acknowledge the problems they face from social distance in a society where the class and caste divisions are rigidly pronounced and strictly enforced. One authority in the field, for example, states that in a country like India a member of one caste could not administer social work services to a member of another.[3] Then too, Kadu-

JOHN M. MARTIN, M.A., *is lecturer in sociology in the Department of Political Philosophy and the Social Sciences, Fordham University, New York, N. Y. Formerly he was director, Curriculum in Correctional Administration, at the University of Notre Dame.*

[1] N. Polansky *et al.*, "Social Workers in Society: Results of a Sampling Study," *Social Work Journal*, Vol. 34, No. 2 (April 1953), pp. 74–80.

[2] W. C. Reckless, *The Crime Problem*, 2nd ed. (New York: Appleton-Century-Crofts, 1955), pp. 233–234.

[3] H. H. Stroup, *Social Work: An Introduction to the Field* (New York: American Book Company, 1953), p. 37.

shin recently suggested that interclass social distance, apparently even in an "open-class" society like our own, may result in referral opposition from lower-class people when they confront middle-class professionals like psychiatrists, teachers, and social workers.[4] However, social workers frequently give little evidence of being alert to the real difficulty that interclass social distance may cause them in fulfilling their professional roles. Thus they fail to see that interclass social distance may reduce the effectiveness of caseworkers from middle-class backgrounds who attempt to assist lower-class individuals. We shall examine this proposition in light of suggestions that interclass social distance in our society has an adverse effect in public opinion surveys, prison interviewing, and psychotherapy.

SOME EFFECTS OF SOCIAL DISTANCE

David Katz attempted to find out how class difference between survey interviewers and respondents influences respondent reaction to the interview situation. His study was carried out in a low-income area of Pittsburgh. Results obtained by industrial workers trained as interviewers were contrasted with results obtained by experienced and inexperienced middle-class interviewers. It was found that results obtained by both groups of middle-class interviewers were significantly different from those obtained by lower-class interviewers. Although there may be no necessary relationship between rapport and similarity of group membership, Katz attributes the difference to "better rapport" obtained by the lower-class interviewers. He suggests that they were more easily able to get at the true attitudes because the lower-class respondents would talk more freely to members of their own class.[5]

Others interested in opinion surveys are also concerned about the adverse effect of class difference on survey results. Sheatsley, for example, writing of class and other group differences between respondents and interviewers, states that bias may sometimes result regardless of what the interviewer may do to eliminate it.[6]

Interclass social distance between inmates and professional staff may also handicap the interviewer in the prison situation. For example, the statement has been made that difference in the social class background of professional staff member and inmate, prison tensions, inmate negativism and selfishness prescribed by the prison culture, and poor interviewing facilities may all be sources of distortion and deception in the prison interview.[7]

Finally, social and behavioral scientists are also concerned that interclass social distance may handicap the psychiatrist. For example, with respect to difference in the social class positions of psychiatrist and patient, it is suggested that psychotherapy may be facilitated if certain similarities in culturally determined symbols and learned drives exist in both therapist and patient; further, that differences in value systems and patterns of communication may hamper the establishment of the therapeutic relationship.[8] In this regard the question is asked: "To what extent can persons occupying positions remote from each other in the class structure communicate meaningfully at the level of abstraction implied in the process of expressive psychotherapy?" The qualified answer suggested is that the greater the distance between classes, the

[4] A. Kadushin, "Opposition to Referral for Psychiatric Treatment," *Social Work*, Vol. 2, No. 2 (April 1957), pp. 78–84.

[5] Reported in H. H. Hyman *et al.*, *Interviewing in Social Research* (Chicago: University of Chicago Press, 1954), pp. 167–168.

[6] P. B. Sheatsley, in M. Jahoda *et al.*, *Research Methods in Social Relations* (New York: The Dryden Press, 1951), pp. 473–474.

[7] N. Johnston, "Sources of Distortion and Deception in Prison Interviewing," *Federal Probation*, Vol. 20, No. 1 (March 1956), pp. 43–48.

[8] J. K. Myers and L. Schaffer, "Social Stratification and Psychiatric Practice—A Study of an Out-Patient Clinic," *American Sociological Review*, Vol. 19, No. 3 (June 1954), pp. 307–310.

greater become the difficulties in communication.[9]

HANDICAP FOR CASEWORKERS

In sum, interclass social distance may be a handicap in a variety of interview situations. We specifically suggest that interclass social distance may handicap caseworkers from middle-class families who attempt the social treatment of lower-class delinquents.

Middle-class caseworkers, despite their professional training and experience, may have difficulty in working with lower-class delinquents for at least two reasons. First, they may have difficulty in communicating and establishing relationships with such children because they have difficulty in taking the role of the lower-class child.[10] To paraphrase Mead on the relationship between social stratification and difficulties in role-taking: how far individuals can take the role of other individuals depends upon a number of factors. One of these may well be differences in social-class experience that make it impossible for persons of one class to enter into the attitude of people from another, although both are affected by and are affecting each other.[11] After suggesting that class differences in roles are in many respects even greater than sex differences, Newcomb states that when interclass differences in group norms and common attitudes are sufficiently distinct, it becomes difficult for members of different class groups to communicate with one another even when they want to communicate.[12] And as Mayer points out, despite exceptions, the whole range of people's behavior and outlook, their entire way of life, varies between the upper, middle, and lower classes.[13] Finally, as Albert K. Cohen has demonstrated with respect to the middle and lower classes, not only are many of these differences subtly absorbed by children but frequently they also become part of the adult way of life.[14]

A second difficulty may arise from the fact that casework relationships, like all social relationships, are reciprocal affairs. Thus, factors stemming from the child end of the worker-child relationship may also stand between lower-class delinquents and middle-class workers. As Hyman and associates state, differential effects arising from group membership differences between interviewers and respondents may result primarily from processes within the respondent rather than within the interviewer, although it is possible that both sources affect results.[15] And, of course, factors arising from the child end of the worker-child relationship are not at all affected by the actions of the worker, his training, or his competence prior to the time he and the child establish contact. After contact, some of the factors resting in the child may be altered through the casework process; some of them may resist change. When change occurs, the child's original perceptions of the worker, as well as other characteristics of the child's personality structure, may simply retard the development of the casework relationship. When such factors resist change, the relationship may never develop.

OTHER GROUP REFERENCES

Now consider the proposition that differences in racial, ethnic, and religious group affiliation may also reduce casework effectiveness. Social distance from these sources

[9] L. Schaffer and J. K. Myers, "Psychotherapy and Social Stratification," *Psychiatry*, Vol. 17, No. 1 (February 1954), pp. 83–93.

[10] For a statement regarding role-taking and its importance in communication, *see* G. H. Mead, *Mind, Self and Society* (Chicago: University of Chicago Press, 1934), pp. 253–255.

[11] Mead, *op. cit.*, pp. 326–327.

[12] T. M. Newcomb, *Social Psychology* (New York: The Dryden Press, 1950), pp. 417 and 566–567.

[13] K. B. Mayer, *Class and Society* (Garden City, N. Y.: Doubleday & Company, 1955), pp. 45–46.

[14] Reported in H. A. Bloch and F. T. Flynn, *Delinquency: The Juvenile Offender in America Today* (New York: Random House, 1956), p. 235.

[15] Hyman, *op. cit.*, p. 158.

may be a more important handicap in casework than that arising from class difference. The visible divisions in American society are not so much those of social class as those of racial, ethnic, and religious group membership. Certainly more public attention has been given to these cleavages than to class divisions. The extensive literature on prejudice and discrimination, the recent United States Supreme Court decisions regarding segregation, the enactment of FEPC-type legislation, and the very existence of such organizations as the National Conference of Christians and Jews, the National Association for the Advancement of Colored People, and the Urban League support such a conclusion.

Granting that such group differences are important sources of social distance in education, housing, employment, and other areas of our social life, it seems likely that they are also sources of social distance in the casework treatment of delinquency. In fact, a number of specialists in delinquency are concerned about just such a possibility. For example, Crawford and others, in discussing the selection of personnel to go into neighborhoods to work with teen-age gangs, ask: "How important is it for the area worker to be of the same race, nationality, or religion as the boys with whom he works?" They merely raise the question. They make no attempt to answer it.[16] However, examination of two of the reports on the Youth Community Participation Project at New York University suggests that adult leadership of youth groups is particularly successful when such leaders are "culturally at home" with group members.[17] At least this appeared to be one of the conditions underlying the success of the church-sponsored group in the project. It seems significant for the thesis of this paper that the leader of this group not only lived in the same neighborhood as did the group members, but also shared the same racial and religious group affiliation as all or most of the group participants.

Research on interviewing also testifies to the barriers set by differences in racial, ethnic, and religious group affiliation. We have clear evidence in public opinion surveys, for example, that the presumed impersonality of the interview situation may not overcome the reluctance of respondents of one racial group to express their opinions freely to interviewers of another.[18] Evidence is also offered that differences in religion, creed, or nationality between interviewers and respondents may also distort results.[19]

These conclusions indicate that, for the same basic reasons that class difference may affect casework results, social distance arising from racial, ethnic, and religious differences may also present difficulty in casework with delinquents.

Of course, many experienced social workers vigorously deny that caseworkers in our society have difficulty rendering service across social and cultural lines. On the other hand, the references presented here indicate that there is considerable basis for drawing the opposite conclusion—namely, that social and cultural differences *are* barriers in casework with delinquents. However, since direct experimental evidence on the subject has not been scientifically accumulated and analyzed, debate continues. Challenged by the rejection of the propositions expressed here, we urge that material from social and behavioral science relevant to this issue be given careful consideration by the social work profession.

[16] P. L. Crawford *et al., Working with Teen-Age Gangs* (New York: Welfare Council of New York City, 1950), p. 141.

[17] M. Harmin, "General Characteristics of Participating Youth Groups," and F. K. Patterson, "Adult Role in Adolescent Subculture Innovation: A Case Study," *Journal of Educational Sociology*, Vol. 30, No. 2 (October 1956), pp. 49–57 and 58–74 respectively.

[18] Hyman, *op. cit.*, p. 159.

[19] *Ibid.*, pp. 162–164.

BY RUTH F. BRENNER

Cultural Implications for a Child Guidance Clinic in a Court Setting

OUR CONCEPT OF the child guidance clinic is based on our middle-class American culture, the culture of a democratic society, which supports among many other principles that of self-determination for the individual. In other words, the individual has the *right* to choose whether he will obtain professional help for a problem with his child or himself, and has achieved the capacity (or so the assumption is made if he has lived according to this middle-class yardstick) to mobilize himself both to seek and select such help, as well as verbalize his problem once he is confronted with the therapist. Since the treatment offered by the classical child guidance clinic has often proved effective with patients and their families, it is only natural that the juvenile court should seek such skilled help for diagnosis and treatment of some of the children who come to its attention by setting up a clinic as part of its service to its young clients and their families.

Once such a clinic is established within the court, there are cultural implications inherent both for the social workers on its staff (as well as the other helping disciplines) and the clients who are ordered by the court to use its services. The purpose of this paper is to suggest some of the problems as well as some of the advantages created by the culture of the court clinic setting for the psychiatric social worker and his client. The psychiatric social worker in the court clinic has a problem in finding his own place, for his identification must of necessity be multiple: he is representative of the community culture identified as middle-class in its broad sense; at the same time, he is a member of a subculture created by the training and discipline of his profession which is not always in agreement with the community mores. It is a fact that neither the worker's personal nor professional values would permit him to support antisocial behavior in his client, yet for him the initial problem is where he can fit in with the court's authoritative and coercive function, since even to him, authority can feel hostile. And finally, he must develop a capacity to identify with and empathize with the culture of his court clients so often at variance with his own values. At the same time, his efforts to understand and empathize with this culture presents him with another problem.

It is against all his training to think in terms of class distinctions, which have so many antidemocratic connotations. Designation by class can sound like a hierarchy of values with one class inherently valid and one inherently inferior. To the sociologist, such class distinctions are used as nomenclature only, for their descriptive value and not in any sense to designate a hierarchy. Rather the value systems that emerge from a group are usually appropriate to their viewpoint and experience, and therefore need to be perceived and considered only as characteristic of the group. Therefore, while this paper may refer to the middle-class identification of social workers and to court children and their families as members of the lower-class

RUTH F. BRENNER, M.S.S., *is senior supervisor at the Bureau of Mental Health Services, Domestic Relations Court, New York City.*

community, the terms are used only in their sociological and descriptive sense without attaching or implying other values to them.

DIFFERENCE IN VALUES

Since the value system of each group meets its needs, it readily becomes apparent that the expectations to which each group has the right for its own members becomes quite unrealistic when applied to a member of the other group. Hence the attitudes of social workers who have not always had experience with our court population can be quite unrealistic regarding even so commonplace an expectation as promptness, or failed appointments. It has been our experience that the children who come to the clinic and their families set less store by schedules and time values than we do. Many of the families have used clinics for medical care where hours of waiting are the rule before seeing the doctor; they are on the relief roles where, again, the application process involves taking one's turn after indefinite periods of waiting; and the court experience itself involves further waiting. Their only experience with a fixed requirement for time might be reporting to work, or for the child, reporting to school, with all the connotations with authority that are inherent in these two activities. In view of their problem, this is scarcely conducive to a positive educational experience in being prompt or responsible about appointments. It must also be kept in mind that few of these families follow anything like a schedule in their daily living, that meals at a set hour at which the family members gather is the exception; rather one eats when one is hungry and except for the younger children in the family, the members will help themselves when the spirit moves them. We find in the clinic that initially the relation to the court's coercive function will bring them in, sometimes for the first few appointments, and then as a relationship gradually develops between the worker and the client, his increased security with the worker may help him to take more responsibility. Such a process may take months before a relationship of such strength is established as to afford the client that degree of security which will help him to keep his appointments with the regularity to which the family agency or the child guidance worker is accustomed.

But who are these court children and what values do their families represent? How well prepared is the court and its clinic, steeped in middle-class culture, to meet their needs? Dr. Molly Harrower, research director of the Court Intake Project, attempts to give us what she calls a "bird's eye view, a sort of composite picture" in her paper, "Who Comes to Court," [1] which summarizes the finding of the research division's study of 229 individuals known to the Manhattan Children's Court. She describes them "as the most deprived, the most hurt, the most ill-nourished, ill-housed, least well-serviced segment of the community."

As already noted, such families have an entirely different set of values which dictate their attitudes, standards, and patterns of behavior. A social worker, student, or staff member from the other helping disciplines in the court or court clinic, needs to be aware of this, if he is to achieve communication and empathy with them. But this is his dilemma, since he is largely influenced by his own class mores and culture so that much of this has to be studied and acquired. The fact that social workers have their uniqueness as a helping profession from their focus *on psychosocial* factors, rather than only on psychodynamic factors, should and does make it easier for them to relate themselves to these clients and to gain an understanding of a culture so different from their own.

After a first interview with Bob, a 14-year-old boy, in which a new worker

[1] "A New Pattern for Mental Health Services in a Children's Court," 1954 Round Table, *American Journal of Orthopsychiatry*, Vol. 25, No. 1 (January 1955), pp. 1–50.

used the same approach that was successful with an adolescent in her previous job, the worker found, apart from the fact that Bob was not in the clinic of his own volition, that her consideration of his interests, his preferences and choices, seemed quite alien to anything in his experience. Her base of reference with Bob was from her own middle-class concepts. For example, our common assumption that adults can be and are friendly to children, in Bob's experience, and that of other children who come to court, is the very opposite. Bob himself could only view adults as he did his mother, rigid and authoritarian, or like the judge or cop, as powerful and threatening. The worker's sympathy, kindness, and interest would be viewed by Bob as deceptive with intent to trap him since she was, so far as he was concerned, a representative of the court. The fact that our middle-class society emphasizes childhood's right to play and enjoyment is repudiated in Bob's world so that the worker's reference to this must have sounded strange. Again in keeping with our value system, to do something out of the usual, as long as it does not compromise our class standards, is a mark of distinction. However, when the worker talked of Bob's "very unusual interest in homing pigeons" (in our experience, not so unusual to some city roof tops and to the boys who live there) to Bob "unusual" may well have meant "crazy." It was apparent that a middle-class social institution, such as the court was to be feared and the worker was seen as some kind of cop seeking evidence or incriminating information for the purpose of punishment.

If the client is from one of the minority groups (and a sizable part of our court population is drawn from ethnic minorities), such perception of the court clinic is intensified, inasmuch as the court is viewed as a white authoritarian setting, where they will not encounter an even break. The concept of fairness is, again, one of white middle-class society, and the court child feels no one will give him a fair hearing. Early in life he has learned to fight for what he needs and wants, and in his community, assaultive behavior is acceptable, and quite within the norm, while it is just the opposite in middle-class society where it is severely condemned.

Education and academic achievement in the lower class are undervalued, partly on a realistic basis, since the chances of academic achievement are severely limited, but instead, the desired goal is to work at as young an age as possible.[2] Along with the devaluation of educational achievement is the lack of verbal communication in such a society. Verbalization is much more limited in quantity and impoverished in quality, and often is used to attack rather than as a means of communication. To talk about feeling is all but forbidden or, if you are angry, you strike, you don't talk. Hence with many of the children we see, we must of necessity find other means of conveying feeling, in addition to words. In contrast, the middle-class child, trained in frustration, who works hard and saves, postponement of gratification is justified by what he is able to achieve. Such a child has grown up in a world where the highest premium was put upon verbal explanations and communication, while all physical expression was frowned upon.

REACHING THE CHILDREN

Since these children are ordered to attend the clinic by the court, it reinforces their group pattern of suspicion and hostility to the worker, whom they conceive of as set to control them at best, or to be extremely punitive at the worst. Therefore, the initial problem for the worker is how to involve them and demonstrate his good will and desire to help. It has been the experience of our clinic that this can be achieved only through concrete expressions of feeling and

[2] Melvin Roman, Joseph B. Margolin, and Carmi Harari, "Reading Retardation and Delinquency," *NPPA Journal*, Vol. 1, No. 1 (July 1955).

participation, *i.e.,* few interviews are held without a coke and often cookies being offered the child or some other appropriate concrete expression of good will. It is a measure of the child's ability to relinquish some of his defensiveness when he is able to eat a little in the presence of the worker, and this is often gradual. Such activities as games, dart boards, and airplane and automobile model building are employed as a bridge to communication—even with 15- and 16-year-old adolescents. For certain situations, woodworking is used, especially for the constricted, passively hostile child who needs a safe outlet for his aggression and hostility. Every therapist, regardless of his discipline, is expected to intervene actively in the environmental situation of the child when it is appropriate, *i.e.,* no adjunct service is given by the social workers, because to these children it is a demonstration of the therapist's active helping interest when he contacts the school or the playground director or whoever it may be where the child is having difficulty.[3]

Group diagnostic interviews are also employed in the belief that by this means the clinic can obtain a rich and fuller picture of the individual's functioning in relation to his peers and peer groups. The children feel more protected in such a situation because they have the comforting presence of their peers when confronted with the unknown and feared therapist. This is by no means economical of time since many more hours go into the analysis of such material than into the individual interview, but it has been found to extend the levels and dimensions of diagnosis.

Attitudes with respect to the psychosexual area in its broadest sense also differ widely in the adolescents who come to court from those who are identified with the middle-class value system. The adolescents known to our court are tremendously exploitative, even assaultive, toward the opposite sex. Middle-class teenagers, on the other hand, are concerned with dating, going to a dance, and ultimately in winning a partner, *i.e.,* courtship, which involves the masculine role of giving and doing, and the feminine role of attracting and receiving. The lower-class teenager is not totally unaware of what the teenagers on the next block do that is different, but characterizes them as "softies" and what they do as "silly." The adolescent who is moving away from his class values will ask as one of our 16-year-old boys in group therapy did, "What's right and what's wrong?"

Because the values the court child and his family take for granted are sometimes alien to us, the first task of the clinic worker in our setting is to become knowledgeable and perceptive about these values. This is not easily accomplished nor can we be chameleons and change our color altogether. There will of necessity be times when our middle-class bias comes through to our client and confronts him with the question "Can the worker ever understand me?" Nor is the problem completely the worker's, for part of it is outside of him but in the legal framework of the court which has values implicit in it that can only seem completely opposed and threatening to the very group it is intended to serve and help.

WORKER REPRESENTS THE COURT

Not only does the clinic worker need to be perceptive about his client's culture in his approach, but his second task is to represent the authority of the court and to achieve its integration with his casework treatment, for without this, the essential task of treatment for these clients will remain untouched.

This task, which the worker must of necessity assume in this setting, often causes conflict in the worker new to our setting for a number of reasons that reflect both personal and cultural biases. How can the

[3] Harris B. Peck and Virginia Bellsmith, *Treatment of the Delinquent Adolescent* (New York: Family Service Association, 1954).

casework principle of the client's right to self-determination be reconciled with the practice of our clinic to accept only those cases which need the court's authority to hold them in treatment (all others in need of treatment being referred to suitable community clinics and agencies)? The answer can be found in two parts: our intake procedure which gives the client a choice of accepting clinic treatment in lieu of reporting to his probation officer or continuing with probation. Having accepted treatment, the authority of the court will be used if he fails to keep his appointments several times in succession in an attempt to deny his need for help. This is the responsibility that the worker must accept in our setting in view of the preponderance of character disorders (or "acting-outers" as Elliot Studt has described them) in contradistinction to the neurotic delinquents who can be engaged in treatment only through the use of authority (they almost never tend to be involved on a voluntary basis).

However, it is not only the need to engage and hold such clients which makes the therapeutic use of authority almost mandatory in our setting, but of equal importance is the fact that the problems of our clients center around their repudiation and defiance of authority. There is the indifferent parent who is caught up by overwhelming problems of economic survival who is inconsistent or indifferent in response to the child's needs of limits and control. There is the authority associated from their tenderest years with punitive and rigid parents whose unreasonable control was carried to the point of almost annihilating constriction, and where the instinct for self-preservation caused them to rebel with intense hostility and open aggression toward all authority, *i.e.*, the adult world as represented by their parents, school, the police, church, or any social institution. Hence the need "for a warm, authoritative, nondelinquent figure" [4] in the treatment of such children—and this is the role of the clinic worker or therapist in the court setting. But to represent a rational authority figure, the worker needs to perceive and resolve his own feelings, distortions, and conflicts about authority. Only in this way will he be able to arrive at an understanding of its supportive aspects. When the situation calls for it, he must be able then to exercise the necessary firmness, where it is therapeutically indicated, or provide the strengths needed to be enabling in a court hearing.

Unless the worker is thoroughly informed and at ease with the rules and procedures governing the court, and knowledgeable in its practice so that he is able to collaborate successfully with court staff in the interests of his clients, not only may he fail them realistically, but he is never an adequate representative of the court to them. They will spot his uncertainty or rejection of the court and he will lose status as well as his greatest value to them as they view it, namely, his supportive role stemming from the authority they see vested in him as court representative.

For example, a segment of a gang in group therapy in the clinic was brought to Adolescent Court (the boys having reached the age of 16 during the year they were in therapy) on a new petition. This focused and greatly heightened their anxiety, but the presence of their group therapist in the courtroom with them was reassuring and meaningful. When he was able to talk to the judge after the finding was made and succeeded in having them continued in therapy in our clinic, it was evident from their comments and those of their parents that this was an indisputable demonstration of his power to help them, and if they were to carry their unspoken thoughts further, it would be, "If he has

[4] Lester M. Sontag, "Problems of Dependency and Masculinity as Factors in Delinquency," in "Psychodynamics of Child Delinquency," *American Journal of Orthopsychiatry*, Vol. 23, No. 1 (January 1953), pp. 1–69.

this power to help me in court, look what he could have done to *hurt* me, but he didn't. Why? Maybe he *likes* me, or maybe there is some other reason, though mysterious." If a worker knows how to take advantage of such situations therapeutically, it opens up new channels for communication and interpretation. This is one of the ways that the client can be helped to change his perception of the court and for that matter of authority, both official and nonofficial, as Dr. Harris Peck has pointed out in his writings.[5]

Thus the worker's conscious use of his authority role "with the acting-outer" will tend to focus and sharpen the client's responses to authority and thus afford the worker an important opportunity to assess diagnostically his client's reaction. He will watch to see whether the client's responses are as though to an enemy—hostile and defensive—or whether he depends unduly on the worker to supply his every need, or attempts to make him his conscience or tries to manipulate and fool the worker. Thus it is only by understanding first the cultural factors and then the dynamics which provoke and stimulate these attitudes, as well as by evaluating their meaning in the therapeutic relationship, that we can begin to make any headway in the treatment of these children.

[5] Peck and Bellsmith, *op. cit.*

Perspective

. . . THIS PROGRESS [in the last hundred and fifty years] throws our present disappointments into perspective. For the simple fact is that men's happiness depends upon their expectations—and the expectations of modern men have grown tremendously. This is the setting in which our present sense that we are going to the dogs must be understood. If there is now a widespread sense of guilt and failure, it is in part because humanitarian feelings have increased, and because the moral sympathies of many ordinary men and women now have an immeasurably greater scope than the sympathies of any but the most exceptional leaders of mankind in the past. If there is a sense that we in this century have a peculiar talent for sin, it is because the collective disasters we have suffered are almost all of them clearly man-made—a token of human power which represents a quite new state of affairs in human experience. If the existence of poverty oppresses us, it is because we do not think it is inevitable. If intellectual inquisitions shock our sensibilities, and seem like inexplicable eruptions of irrationality, it is because our moral expectations have been profoundly altered by the prestige which institutions of free inquiry now enjoy. And if we are worried about the chances of the human race for survival, this is painful, but it is a little like the gout. Most men in the past, most men in Asia and Africa today, have had to worry about their own short-run personal survival.

From *The Case for Modern Man* by Charles Frankel (Harper, 1956)

BY FLORENCE E. CYR AND
SHIRLEY H. WATTENBERG

Social Work in a Preventive Program of Maternal and Child Health

A MATERNAL AND child health program, which is primarily concerned with the development of healthy mothers and babies, offers a rich opportunity for social casework directed not only toward physical health, but also toward emotional and social well-being. Promotion of good mental health in the mother, the key figure in the life of her baby, can do much in creating a healthy social and emotional climate for the development of her child's personality.

It is well established that many emotional disorders and social maladjustments originate in this early period of life, in the mother-child relationship in particular, and in family life in general. It is a potentially critical period for the mother, especially during the pregnancy and immediate postpartum period when there are biological and emotional changes going on within her that are peculiarly related to her role as a woman and mother. Preventive or interventive measures during this period may enable her to resolve stress in such a way that she does not involve her child in her own problems and will be free to recognize and meet his needs. Hopefully, a woman can emerge from her first experience of pregnancy with a healthy realistic attitude toward child-bearing which will act as a positive force in future pregnancies.

An ideal maternal and child health program can offer a mother guidance through her child's infancy that will foster healthy relationships and prepare her to meet emotional and physical hazards commonly experienced during this period. Total family interrelationships and the father's role should be recognized and his participation in the program encouraged.[1] These goals have been a primary consideration in the maternal and child health program discussed in this paper.

THE FAMILY HEALTH CLINIC

In 1950, under the auspices of the Harvard School of Public Health, affiliated for this purpose with the Boston Lying-In Hospital and the Children's Medical Center in Boston, the Family Health Clinic was established to provide a service-study program for health supervision of mothers and infants.[2] This clinic, supported by a special grant from the Association for the Aid of Crippled Children of New York and the Charles P. Hood Dairy Foundation, has offered complete service in prenatal, postnatal, and well-child care to 116 families having first babies. The mothers came

FLORENCE E. CYR, M.S., and SHIRLEY H. WATTENBERG, M.A., *are assistants in social work at the Harvard School of Public Health, Boston, Massachusetts.*

[1] O. Spurgeon English, "Psychological Role of the Father in the Family," *Social Casework*, Vol. 35, No. 8 (October 1954), pp. 323–329. *See also* a paper by Rose Bernstein and Florence E. Cyr on a study of interviews with husbands in a prenatal program to be published in a forthcoming issue of *Social Casework*.

[2] Gerald Caplan, "Preparation for Healthy Parenthood," *Children*, Vol. 1, No. 5 (September-October 1954), pp. 171–175.

from the regular outpatient department at Boston Lying-In Hospital and selected to participate in the program, knowing that it embodied both service and study aspects. The criteria for their participation, other than being primiparae, were that they have no medical or physical complications requiring attendance at other special clinics, and that they live nearby for convenience in continuing with the clinic for at least one year after the birth of the child.[3]

The Family Health Clinic has a multidiscipline staff consisting of obstetricians, pediatricians, nutritionists, public health nurse, social workers, and consultant psychiatrist, all of whom were available to serve the patient or family during the pregnancy and, with the relationship established, after the birth of the child. There has been a well-formulated and close, cooperative, working arrangement with the Visiting Nurse Association. Other community agencies have also been called upon when needed for specialized services.

The project has allowed for carrying out the dual responsibilities of service and study. Because the clinic has devoted a great deal of staff and time to a small number of patients, its program is not in all respects adaptable to general use. But it was not designed to serve this purpose. Rather, it has been a clinic where service could be examined and evaluated, and where increased understanding of pregnancy and infancy could be gained. Some of the techniques and knowledge described may be helpful to others involved in planning programs and giving similar services to mothers and children.

The atmosphere of the Family Health Clinic was specifically planned to implement preventive mental health services for the pregnant woman. Although her relationships with the clinic staff were only a small part of her total social experience, these relationships were occurring at a potentially vulnerable time in her life, and the way in which her physical and emotional needs were met was important. The clinic was designed to represent the warm, accepting atmosphere that is an attribute of the good mother—the very kind of relationship it was hoped she could foster for her child. In pregnancy, passive-dependent feelings are normal, often even accentuated. These feelings were encouraged to a degree that might not be considered appropriate except during this special period of her life, and were based on the psychiatric assumption that this would enable her later on to fulfill the same kinds of needs in her infant. In the words of the consultant psychiatrist, "It is similar to filling a reservoir for later use." Not only did the clinic as a whole often represent the mother figure, but individual staff members, especially the social workers, were given this attribute by the patient. The kind of relationships the patient made with each member of the staff gave valuable insights into future parent-child relationships.

Since there were many persons serving one patient, a unified treatment plan was imperative. This was accomplished by preclinic and postclinic conferences during which each staff member shared his knowledge of the patient and family seen on a given day, and during which a treatment plan and goal were formulated, evaluated, or revised. There were also special conferences with the psychiatrist during which staff members could initiate full discussion of a particular family if additional consultation seemed necessary. Detailed information was exchanged freely by members of the team as the need arose, both through formal records and informal conversations. These experiences also highlighted a well-known fact, namely that individuals working together on a team need to understand each other's techniques, frames of reference, and goals so that the patient will receive service free of professional misunderstandings or confusions.

[3] The clinic discontinued active service to patients in 1956. Its staff is now engaged in disciplinary and interdisciplinary studies based on the accumulated data.

ROLE OF THE SOCIAL WORKER

The role of the social worker in this clinic was comparable to her role in any multidisciplinary setting where she offers direct service to clients with problems and shares knowledge of social factors with the staff. As the specialist in social relationships, she was responsible for evaluating those key figures in the patient's environment who were important in a given situation.[4] In addition, because of the nature of the clinic's goals and its study purpose, all patients were seen routinely by the social worker thus providing opportunities for preventive work as well as for gathering data.

The patient was usually seen by the social worker eight to ten times in the prenatal clinic and monthly at the well-child clinic; other visits, to the home or in the office, were arranged if necessary. There was, also, at least one ward visit made during the eight-day period of hospitalization, although more frequent contacts might have been helpful.

Casework interviews were primarily unstructured in an effort to find out what the patient herself wanted to discuss. However, the content of the interviews was influenced by the casework plan and by the introduction at particular periods by the social worker of certain subjects based on her knowledge of the common problems of pregnancy and infancy. Thus for study and preventive purposes, there was a flexible semistructured interview aimed toward particular goals that the worker wanted to achieve.

The husband, often an unknown entity in such a program, was encouraged to attend the prenatal clinic with his wife and to come with her when she brought the baby for medical supervision. Occasionally, other close relatives were included to facilitate a treatment plan. In the majority of cases the husband was seen at least once. (Initially, this was interpreted as one of the requirements for the patient's participation in the clinic, but daytime employment was a practical obstacle in some cases. It was not possible to hold evening clinics even though it would probably have encouraged greater husband participation.) Because the individual interview and joint interview each had distinct advantages, it was found that a combination of both types produced the greatest understanding of the total family. When husbands did attend, either alone or with their wives, it was clear that the knowledge gained added greatly to the staff understanding, broadened the effectiveness of service, and offered an opportunity for help to both parents during this crucial period of family change and development.

In addition to the several visits by the visiting nurse, the social worker usually made a home visit during the period between hospital discharge and the first clinic appointment with the baby.[5] During this visit problems could be discussed, family interaction and home atmosphere could be observed, significant behavior patterns noted, and general understanding increased, to aid the staff in giving future health supervision. The values derived from the home visit suggest that a visit during pregnancy and evening visits to include the husband would have added advantages.

Each mother used the home visit according to her own needs, but often the social worker had to focus the interview in a helpful way. Problems that had loomed large in pregnancy were submerged, but the social worker's awareness of them as part of the personality structure guided her in treatment. During this period of readjustment, it was often necessary for the worker to make clear her continuing in-

[4] Gerald Caplan, "The Role of the Social Worker in Preventive Psychiatry," *Medical Social Work*, Vol. 4, No. 4 (September 1955), p. 147.

[5] Sibylle Escalona, "The Psychological Situation of Mother and Child Upon Return from the Hospital," in *Problems of Infancy and Childhood* (New York: Josiah Macy, Jr., Foundation, 1949), pp. 30–96.

terest in the mother since the mother frequently felt that the baby had become the center of attention.

Until the baby was four or five months old, the relationship between the mother and worker was somewhat different than before—now the patient was closer to the pediatrician, nurse, and nutritionist because of the focus on the physical care of the baby. Primarily, the social worker maintained a supportive relationship, and not until several months had passed were patients able to talk about many intrapersonal problems that were apparent in other ways to the worker. In retrospect, mothers described overwhelming feelings of inadequacy, annoyance, and distress about motherhood and themselves. Some had resolved these feelings in a healthy way, but others had not. However, the past supporting relationships with the caseworker enabled them to enter into a treatment situation more readily, which indicated that the social worker should not withdraw during the early infancy period. This experience also demonstrated the fact that need for casework help might be present but not evident at this time, and that workers need to develop skill in identifying these needs and formulating techniques to deal with them.

TREATMENT FOCUSED ON PREVENTION

All families attending the Family Health Clinic were seen by the social workers for preventive purposes. The usual methods employed in any casework situation were used, but the difference was that treatment was focused on and related to good mental health in mother-child relationships, and the formation of a stable, healthy family equilibrium. This focus was achieved by giving particular consideration to the attitudes of the wife and husband toward pregnancy and parenthood; to their relationships with their own parents; and to the family potential for fostering healthy experiences for the child.[6] Past and present personality difficulties of the parents were evaluated; then a decision was made as to whether these might invade parent-child relationships, and if so, whether intervention could prevent this happening. Certain casework techniques were considered applicable to work with all women undergoing this common experience, but at any time the caseworker could be flexible and discriminating according to the needs of the individual patient.

Ego support. Ego-supportive treatment was used with the patients of the Family Health Clinic to reinforce and strengthen the capacities of these essentially healthy women to deal specifically with the experiences of pregnancy and early motherhood. Particular attention was given to such matters as attitudes and feelings about the pregnancy; the patient's image of herself; the way pregnancy and parenthood affected personal and family goals and husband-wife relationships; stresses created by physical and emotional changes of this period; anxieties about labor and delivery; and doubts about capacity for mothering and assuming a new role. The value of this treatment method can readily be seen in a prenatal and well-child service, and it was utilized not only in social work treatment but permeated the entire atmosphere of the clinic. Ego-strengthening measures were often sufficient to enable patients to function with a minimum of disorder and to approach parenthood with healthy attitudes.

Clarification. At times the technique of clarification for specific problems that might affect the mother-child relationship was used. This meant treatment of a more intensive nature and involved help to the patient in understanding her conscious attitudes and behavior, which required broader knowledge of the individual personality

[6] Herschel Alt, "Mental Health Planning for Children," *Social Casework*, Vol. 31, No. 2 (February 1950), p. 50.

and social situation. The social worker did not attempt insight development. Clarification was indicated with the patient who seemed unable to resolve feelings about the experiences of pregnancy and parenthood noted above, or who had such problems as unusual doubts and anxieties, traumatic experiences connected with the pregnancy, disordered relationships indicating possible transference of inappropriate feelings into the mother-child relationship, or confusions about femininity and motherhood. If the problem was so acute that it could not be resolved without some change in the personality structure, treatment was directed toward recognizing this and getting psychiatric help. In most of the cases in this clinic, however, this was not necessary.

Modification of the environment. To illustrate some of the realistic social aspects of family living, all families received help in planning for a healthy social environment; *e.g.,* living arrangements that would foster optimum physical and mental health during the pregnancy and later on; economic, educational, or vocational adjustments; management during the period when the mother returned from the hospital with the baby. In some cases more specific treatment was necessary to enable the patient to have a less critical experience emotionally. This was done not only by having the clinic staff meet the woman's needs in a specialized way, but also by encouraging those in her family to do this as well.

Anticipatory guidance. Another method, sometimes designated as educational, was anticipatory guidance, which is particularly applicable in a preventive service. In the clinic, anticipatory guidance was twofold. It was used to encourage better understanding on the part of both parents of the normal changes in growth and development common to pregnancy and early childhood. It was also used as advance preparation for meeting the stress situations of this period with less anxiety, and in a way that favored a healthy outcome for the mother as well as her relationship with her child.

Anticipatory guidance included giving information, but also necessitated participation on the part of the wife and husband and expression of their feelings. Such participation, or even lack of it, gave the social worker clues about possible sensitive areas where interventive work was needed. The use of anticipatory guidance assumed that the social worker had a sound background of knowledge of the normal physical and psychosocial factors of this period, and the skill to give information without producing anxiety.

Since the crises and stresses of pregnancy vary from woman to woman, only those that were most common and identifiable were discussed. For example, the emotional lability and irritability of the pregnant woman; the changes that often occur in sexual feeling; the probable increase in passive-dependent needs as the pregnancy progresses; variations in development of full maternal feeling; attitudes about breast feeding; and the worries about a healthy outcome for mother and child.

Some preparation was also given during pregnancy about the physical and emotional reorientation of the mother after the birth of the baby, and for the time it takes after delivery for her biological and emotional system to readjust. Most prospective mothers are unprepared for feelings of annoyance and timidity toward their babies. Discussion about such matters was found to have most value late in pregnancy, or in early infancy, when the baby was better established as a reality. Even in pregnancy, thought was given to the impending shift in the husband-wife relationship, the changes in family life resulting from the birth of the baby, and the growth and satisfactions that would emerge in the family unit. In considering the early postpartum period beforehand, the idea was expressed that husbands could be helpful and enjoy participation in infant care, and that this could enrich their own experience in parenthood as well as be a source of support to the wife

at this time and enable her to give the baby the mothering that is required.

Anticipatory guidance after the birth of the child was predicated on the worker's having considerable knowledge of the growth and development of the normal child as well as patterns of family development and interaction. This guidance (given by other members of the team, also) quite naturally differed in content during the various periods of the baby's development, and was related to such matters as weaning, nursing, socialization, curiosity, exploration, beginning independence, negativism, toilet training, and changes in food and sleep patterns. In the interviews, staff members attempted to avoid generalities, and, indeed, anticipatory guidance was a means of clarifying misinterpretations gleaned from outside sources.[7] The ultimate goal was to help the mother see the child as an individual from whom she could take her clues as to his needs and readiness for change. Many of the women expressed a positive response to this kind of treatment and felt that they had been much better "prepared" for their experience than their friends who had not had a chance to discuss such matters.

ILLUSTRATION OF METHODS

The following cases illustrate some of the methods used by the social worker in the Family Health Clinic, and show some of the ways the staff worked together, picking up clues and sharing a unified treatment plan:

A twenty-eight-year-old woman who had been enthusiastic about joining the Family Health Clinic had a pleasant but reserved manner at her first visit. On her second visit she was quite diffident with the obstetrician and nutritionist, and left before the social worker could see her. In case conference the first visit was reviewed. The doctor recalled that the patient's reserve had impelled him to resort to numerous questions to indicate an interest in her. The nutritionist had asked many specific questions about the patient's food intake as part of the routine method of collecting dietary data. The social worker had kept the patient waiting while she had other interviews. The consultant psychiatrist pointed out that this woman's reactions indicated she had probably been unable to give of herself in response to questions, and felt hurt and deprived by what she misinterpreted as the disinterest of the social worker. It was felt that she might see pregnancy as a depriving experience and might involve her feelings in attitudes toward her baby. The larger question was whether she could tolerate giving to the demands of an infant.

At subsequent appointments all of the staff made efforts to give to her, rather than take from her by questioning. The obstetrician gave her information about pregnancy, and used questions only when necessary to ascertain her physical condition. The nutritionist put dietary recommendations in terms of a good diet rather than stressing necessary omissions of food. As might be expected, this woman resented restrictions in her diet. Therefore, the technique of helping her to see diet as a medical prescription, for her good, was used. This discouraged stresses around food as such, which might have been paralleling old difficulties with her mother and be carried on later in child feeding.

The social worker handled directly the feelings which had arisen because of the delay in arranging an interview, and pointed out her constant interest and availability. This woman responded by discussing herself quite freely, which seemed an encouraging sign of her ability to meet her child's needs if she had sufficient satisfactions herself.

The pediatrician, who became acquainted with the prospective mothers in

[7] M. Robert Gomberg, "The Responsibilities and Contributions of Social Work in Strengthening Family Life," *Social Casework*, Vol. 34, No. 8 (October 1953), p. 331.

pregnancy, was able to outline a régime for the baby in line with the woman's needs, and one which emphasized the satisfactions the baby could give to her.

The social worker, in a joint interview with the parents, was able to encourage the husband toward active participation in meeting his wife's dependency needs. These were masked by her aggressive independence which had frightened him away from giving the help and solicitous attention she wanted. Through a routine discussion of passive-dependent needs of pregnancy, he became more comfortable in doing things for her, and she was more accepting of them as appropriate. Again, since she accepted this change without undue anxiety and could see dependent feelings as permissible, it was felt she might be able to tolerate her infant's dependency.

The parents were seen together after the birth of the baby and the husband was encouraged to continue giving his wife attention in the postpartum period, and to carry out his desire to take part in baby care. He had been reluctant to consider this, thinking his wife would object and that it was not a manly activity. He was surprised and pleased when she welcomed the plan, and a few months later she told the worker that this had been an important factor in uniting them as a family.

ANOTHER ILLUSTRATION

A young woman who seemed to have a good personal and social adjustment in marriage, work, and general relationships became upset when her mother began to make financial and emotional demands upon her during pregnancy. This pressure came at a time when she was experiencing normal, passive-dependent feelings herself, and reactivated the experiences of her adolescence when her mother was overly dependent upon her after her father's death. She became so anxious she could not tolerate her own dependency feelings and engaged in compulsive activity which was threatening her health in pregnancy. She openly expressed fear that if she allowed herself to become dependent, her child's relationship with her might follow the pattern of her relationship with her mother.

It was the opinion of the staff that this women had many positive potentials for a healthy relationship with her child, but that intervention was indicated for the sake of her health and to prevent her involving the baby in her problem with her mother.

The woman was encouraged by the social worker to discuss her own usual adequate functioning, to see her present dependency feelings in true perspective as appropriate and different from the kind of behavior her mother had shown, and in general to clarify her feelings. She was given some help with her current guilt feelings about inability to meet her mother's demands, but this was done around the current situation, without any attempt to deal with the old problem. She responded by becoming less tense and less impelled to hyperactivity, and although doubts occasionally plagued her because of the proximity of her mother, there was no evidence during the period in which she was known to the clinic that the problem affected her relationship with her child.

OFFERING PREVENTIVE SERVICE

In a health program such as the Family Health Clinic, the social worker was offering service to many individuals who had no established pathology and who were not seeking help with social or emotional problems. Not only the patient, but also the worker, had to make some adjustments in thinking in order to enter effectively into a helping relationship. The social worker was in reality obliged to take a more active role than was her custom—she was incorporating educational techniques with which she was not entirely comfortable at first, and had to develop skill in offering preventive services in a meaningful way. There was some evidence of patient resistance,

even more unconscious than conscious, because of the usual connotation of social workers with pathology. It was rewarding, however, to see how quickly most of the patients and families in this clinic oriented themselves to this type of service from the social worker.

CONCLUSIONS

The Family Health Clinic has demonstrated the value of having several professions join together for the guidance of families on the threshold of parenthood. Special emphasis was placed on the promotion of good mental and physical health through incorporation of preventive measures. The social workers employed casework methods common to general practice, but adapted them to the particular goal of prevention. Also, the treatment was focused on the reinforcement of capacities to handle crises or stress situations and the development of healthy relationships during the period of pregnancy and infancy. The usual techniques of ego support, clarification, and modification of the environment were used. In addition, educational methods were applied to advantage and included anticipatory guidance.

It is recognized that the concept of prevention need not be confined to programs established exclusively for this purpose. However, in order to do preventive work, the social worker needs to have special understanding and knowledge about the normal or usual experiences of life. It has been relatively easy to identify pathology, but less easy to make a differential diagnosis as to when a normal life experience may become pathological. The social workers in the Family Health Clinic are making a detailed study of the social and emotional problems occurring in pregnancy and the immediate postpartum period, although the number of cases studied will not be statistically significant for conclusive results. However, through identifying these problems and the periods when they occur, it is hoped that more dynamic and timely service may be given.

BY SIDNEY E. ZIMBALIST

Welfare Planning Research: Master or Servant?

HUMAN NEEDS, BEING largely culturally determined, are potentially unlimited. As our level of civilization advances, as our social values and standards change, our ideas of what people should have in order to attain a proper level of living, also evolve and progress. It follows, therefore, that those involved with the study and meeting of human needs—and that includes researchers and practitioners—are faced with a peculiarly elusive concept. We are seeking to weigh and handle an entity whose very recognition is dependent upon a point of view, a scale of values, which is constantly shifting and evolving.

We know, for example, that minimum budget needs of dependent families are placed at a much higher level today than a century ago (inadequate as they still may be!). Recognition of the need for humane care and treatment for the mentally ill is a relatively recent development. Even more belated is the realization that the aged have needs which should be met by community programs. We are, today, undoubtedly blind to many "needs" which future generations will consider obvious. In just this way does our level of civilized values advance.

When we speak of welfare "needs," therefore, we are dealing not so much with matters of fact, as with matters of social conscience. Every perception of a "need" is rooted in the value system of the perceiver. Facts, after all, never really speak for themselves. They must be interpreted within a particular frame of reference before their voice can be heard and understood. Here we encounter a "principle of indeterminacy" which creates for social research a fundamental difficulty much greater than that encountered in the physical sciences. The scientific method depends upon the observation of objective phenomena; something as subjective in nature as a welfare "need" appears to fall outside its usual province.

This certainly is one reason for the confusion and ambivalence surrounding the role of research in welfare planning. As a result, we find that attitudes toward research in this field vary widely. At one extreme are those who look to research for authoritative guidance in setting planning directions and program. "Tell us what is needed," they ask of researchers. "Tell us further which needs are most important, and in what sequence they are to be met. We will then act on your findings and work toward putting them into effect." This view may be characterized as "research overdependency." Those suffering from it tend to look upon research as an infallible master guide to be followed in penetrating the maze of welfare planning issues and problems.

At the opposite pole are those who either distrust or question the contribution that research can make to welfare planning. "We *know* from experience what is needed," they say. "Just give us some supporting facts and figures. Why bother to study the situation when it's a foregone conclusion anyway?" This attitude may, when carried to an extreme, be described as "research rejection." Its exponents prefer to rely upon personal judgment and experience, calling only upon research, if at all, to serve and support their preconceived conclusions.

There is, happily, a third alternative, but I will withhold comment upon the

SIDNEY E. ZIMBALIST, D.S.W., *is research secretary, Health and Welfare Council of Indianapolis. This paper was presented in June 1956 at the annual meeting of the NASW San Bernardino-Riverside, California, Chapter at which time he was assistant research director, Welfare Planning Council, Los Angeles region.*

more desirable role of research in welfare planning until a later point. Let us first take a closer look at the two extreme attitudes we have sketched in, extremes which, while not often encountered in their pure form, frequently enter in some degree into these relationships and hamper teamwork.

RESEARCH AS MASTER

The tendency toward "research overdependency" is quite understandable in a culture which is increasingly "science-oriented," and dependent upon its works. Certainly in the physical spheres, the scientific method has, within a few centuries, wrought miracles in opening up new stores of knowledge and power, and in multiplying our material wealth and productivity. And this revolutionary impact of scientific and technological advance appears, if anything, to be accelerating with the passage of time. Under these circumstances, it is not surprising that we look to science for guidance and the solutions of our social problems, and to the scientist for answers to our planning questions. After all, if the scientific method has taught us increasingly how to master and control the physical forces and elements, can it not do the same for social problems and processes? Why should we not turn to research, therefore, to tell us what services the community needs to meet its problems?

The answer is that there is a crucial dimension to social welfare questions which does not arise in the same way in the study of physical problems—the dimension of *social value*. To pursue this point, let us return to the question of "welfare need." What precisely does this term mean? Most people would agree that, stated broadly, a "welfare need" refers to a situation which a group or community considers to be socially undesirable, and which it therefore undertakes to eliminate or reduce through appropriate means. But the determination of what is "socially undesirable" is basically *not* a research issue; it is an ethical issue. The scientific method, after all, is a *method* only, however powerful, and we are now concerned in speaking of values with the question of ends. Research can of course contribute mightily to the achievement of given objectives and we shall elaborate on this in a moment. However, it cannot of itself determine what those objectives shall be. This is a matter that only the community can decide for itself.

But, it will be pointed out, research can surely identify conditions and their causes, show us the relationships between significant factors, predict the consequences of alternative courses of action, tell us what the "facts" are. Isn't this the same as determining "needs"? Research may be able to do these things, within limits, but these alone will not reveal "needs." For how can we know which conditions are "benign" and which are "malignant," which factors are "positive" and which are "negative," which consequences are "desirable" and which are "undesirable"? Only from the standpoint of a set of social values regarding the kind of community in which one *prefers* to live can we ultimately make these distinctions.

For example, in connection with the question of "needs of the aged," there is growing agreement that the dependent aged should be provided basic services by the community to insure their physical and emotional well-being. Their needs for economic security, for medical care, for useful occupation, for recreational outlets, for housing, for rehabilitation where feasible and for humane custodial care where it is not, are being increasingly recognized. We all know of cultures in which the aged and infirm are ritualistically done away with; their needs are summarily met with, once and for all! Is it possible *scientifically* to establish that this is socially undesirable? Can we *prove,* objectively, that the aged should be humanely treated to a full and rich twilight of their years? Hardly! Social values cannot be compared, like cigarettes, by laboratory test. The issue again, is simply this: In what kind of

community does one prefer to live? One in which the aged are liquidated? One in which they are permitted to shift for themselves? One in which they are helped to basic necessities? One in which they are helped beyond this to a realization of their individual capacities and interests? The choice is the community's, *not* the researcher's. Or rather—insofar as we are all a part of the same community—the choice is ours together.

Some of the tendency to elevate research to an excessively dominating role reflects, I think, some lack of agreement regarding the proper role in planning of the profession itself. Ever since Porter R. Lee pointed out the duality of social work in serving both as "cause" and "function" in his presidential address before the 1929 National Conference of Social Work, and ever since Wilbur Newstetter adjured social workers to be "on tap—not on top" in regard to the welfare planning process, the place of the professional community organizer has been an ambiguous one. The tendency for many years now has been to adopt a primarily facilitating, enabling role, and to avoid assuming leadership functions. When, therefore, the lay community has looked to the profession for guidance in identifying problems and needed programs, we have not always been sure how to respond. One answer has been, "Let's make a study." Research has thus been used to fill the vacuum of leadership created by the shift in professional function. Research, under such circumstances, is forced into a position which it is not entirely qualified to fill.

In some ways, these limitations of research are well known. Social workers all recognize the importance of the nonobjective elements in human affairs. The resistance of a community to the extension of welfare services, however, is not merely a matter of insufficient knowledge and lack of facts. The opposition to our programs is equally if not primarily a measure of the emotional friction generated in the process of lifting a community's scale of values to a higher level. Every sound advance in the provision of welfare service represents a sharpening and strengthening of the community's sensitivity to human values. These are the growing pains of conscience. Undoubtedly, this accounts for the unpopularity of the profession in certain quarters, for social workers are logically looked upon as a symbol of the community's conscience . . . and who likes his super-ego?

THE RESEARCH CONTRIBUTION

Having emphasized the limitations of research when looked upon as "master" in the planning process, before considering the opposite extreme, let us sketch in briefly the role that research can legitimately be expected to play in the study of welfare needs. One helpful way, for research purposes, to distinguish between two aspects or dimensions of the "need" concept, is as follows:

1. An internal *condition* within the individual or group which is considered "socially undesirable," and
2. An external *service* which is considered appropriate to meet or alleviate this condition.

The first requirement for effective research into need is some initial agreement as to which conditions are to be focused upon. True, research can contribute significantly to the clarification and logical conceptualization of the conditions which are to be the object of the community's concern, but, as we have seen, research cannot make this selection itself. Once, however, it has been *given* the conditions to be studied, research is then potentially able to proceed in a number of significant ways, which include:

1. Redefining the need-condition (if necessary) in empirical, verifiable terms.
2. Determining or estimating the incidence, range, and distribution of these conditions within a particular population.

3. Identifying the background characteristics and factors associated with these conditions.
4. Describing and measuring existing services provided to meet these needs.
5. Evaluating the effectiveness and adequacy of these services.
6. Estimating the extent of unmet needs, and so on.

Obviously, these are crucial matters and essential to intelligent social planning. But it should be noted again that they all follow *from* the community's identification of its own areas of concern. Nor can it be expected that these legitimate functions of welfare planning research will be accomplished quickly or easily. Sound welfare research is an exceedingly time-consuming and demanding process, and unfortunately the scientific tools and techniques as yet at our disposal are frequently crude and limited in relation to the subtle and complex subject matter with which social work deals. Some of the requests that come to researchers from planning groups are like asking a physicist in Newton's day to come up with an atomic bomb for next Tuesday's committee meeting!

RESEARCH AS SERVANT

At the opposite pole from those planners who look upon research as "master" are those who consider it as "servant," subject to their control and direction. Of course, there is a broad sense in which everyone in research and in the social work profession are servants of the community and of our clients. But here the term "servant" is used in its primary sense of one who unconditionally carries out the wishes of others. Research obviously cannot thrive under such conditions.

Pressures are sometimes brought to bear upon research to provide data which support a predetermined conclusion. Undeniably, planning groups frequently do have experience and knowledge that lead them to convictions regarding what is needed in a community; and it is entirely proper that they should look to research, public interpretation, social action, and other disciplines for aid in accomplishing these purposes. When research is called into the picture, however, it must be on the basis that judgment is suspended until the facts are in, and if necessary that preconceptions will be reconsidered. Research integrity requires freedom, from either direct or indirect influence, to pursue a question with open mind and eyes. The researcher himself may legitimately be fully convinced of the proposition he is called upon to study; but he must be sufficiently free—both internally and externally—to avoid selecting only those facts which fit, and to be accepting of those which do not. Otherwise, his product is not research, but propaganda, however constructive it is.

For when the research process is brought into play around a question, there is necessarily implied a "gentlemen's agreement" by all parties that every effort will be made to gather and present all significant facts pertaining to the question. When the research process is entirely subservient to the planning group, and is expected unconditionally to support its specific proposals, there are risks that the rules of the scientific game may be broken, whether consciously or unconsciously.

The temptation to yield to a slanted and partial type of research is particularly great in welfare planning, where the proposals research is asked to study are in most cases constructive and humanitarian ones. Why then lean over backwards to observe full protocol, and belabor all sides of the question? If the cause is worthy, why not provide the figures needed to make the case? It is easy for practitioners and researchers alike to lose sight of the point that, even in the context of meritorious welfare causes, the ends do not justify the means.

The danger, of course, in yielding to this temptation is that where such practices prevail, they will ultimately be seen through. Research stands for nothing if it does not stand for reasonable accuracy and impar-

tiality. People eventually will come to suspect a field of "research" which mechanically grinds out selected facts and figures tailored to promote a particular point of view or program.

These are not idle fears. There are numerous examples in social work history of research being used in this way, to the detriment of both research and the profession. The social survey movement itself, which dominated the entire field in the early decades of this century, was frequently guilty of such excesses in its zealousness to dramatize the social ills of the day. After its first popular impact, a wave of reaction against the survey movement set in, which drastically modified and limited its scope and methods. It seems likely that these abuses, in addition to contributing to the decline of the classic survey in its original form, may also have put back the cause of sound research in social work a good many years.

The problem still exists as witness a recently completed study of mental health needs in a West Coast area. The planning group requesting the study was convinced from the outset that the primary need in this area was for a psychiatric clinic. The first job was to get them to see that a study could not be set up expressly to document this need; that it would have to be posed for research as an open question. The study findings showed that there was indeed an important need for psychiatric outpatient services, but that there were other types of services needed as well—in particular, expanded family casework services.

Whatever the outcome, the position of research seems clear. Having launched upon a research undertaking in good faith, research has a responsibility to see the study through and submit its findings as they emerge—let the chips fall where they may!

Just as research makes a poor "master" in the business of planning, so does it make a poor "servant." In the one case it usurps the proper role of planning and community judgment; in the other, it fails to maintain that measure of independence and freedom of inquiry which is vital to its integrity. What then is the proper place of research in the planning picture?

PARTNER AND COWORKER

The title of this article—unfairly perhaps—poses a false dichotomy. The answer to the question—"Welfare Planning Research: Master or Servant?"—is that it should be neither. The answer proposed here is that, in order to be true to itself, and as useful as possible to the profession, welfare planning research should be employed as the full partner and coworker with planning. Only on the basis of equal, co-ordinate, and collaborative status with planning—working side by side, preferably within the same setting—can the best contribution of both be realized.

From planning groups, research needs to obtain: the initial determination of specific problems and needs and services to be studied; the particular purposes and objectives envisaged; the standards and priorities of service to be considered; and the freedom to work sufficiently thoroughly and objectively to maintain scientific standards. From research, planning can obtain: logical clarification of the needs, problems, services, and priorities under consideration; objective data regarding the nature, extent, and distribution of the needs selected for study; analysis of the characteristics and amounts of existing services; tests of the effectiveness of services and their underlying theories; and the assurance that the facts and theories upon which planning and services are based are as reliable and valid as existing research methods can make them.

On this equilateral basis of mutual understanding and shared responsibility, welfare research and welfare planning will best be able to move forward together, each making its distinctive and essential contribution to our common objectives and ideals.

BY ERNEST GREENWOOD

Attributes of a Profession

THE PROFESSIONS OCCUPY a position of great importance on the American scene.[1] In a society such as ours, characterized by minute division of labor based upon technical specialization, many important features of social organization are dependent upon professional functions. Professional activity is coming to play a predominant role in the life patterns of increasing numbers of individuals of both sexes, occupying much of their waking moments, providing life goals, determining behavior, and shaping personality. It is no wonder, therefore, that the phenomenon of professionalism has become an object of observation by sociologists.[2] The sociological approach to professionalism is one that views a profession as an organized group which is constantly interacting with the society that forms its matrix, which performs its social functions through a network of formal and informal relationships, and which creates its own subculture requiring adjustments to it as a prerequisite for career success.[3]

Within the professional category of its occupational classification the United States Census Bureau includes, among others, the following: accountant, architect, artist, attorney, clergyman, college professor, dentist, engineer, journalist, judge, librarian, natural scientist, optometrist, pharmacist, physician, social scientist, social worker, surgeon, and teacher.[4] What common attributes do these professional occupations possess which distinguish them from the nonprofessional ones? After a careful canvass of the sociological literature on occupations, this writer has been able to distill five elements, upon which there appears to be consensus among the students of the subject, as constituting the distinguishing attributes of a profession.[5] Succinctly put, all professions seem to possess: (1) systematic theory, (2) authority, (3) community sanction, (4) ethical codes, and (5) a culture. The purpose of this article is to describe fully these attributes.

Before launching into our description, a preliminary word of caution is due. With respect to each of the above attributes, the

ERNEST GREENWOOD, Ph.D., *is associate professor at the School of Social Welfare, University of California, Berkeley.* *The writer is indebted to Dr. William A. Kornhauser, Sociology Department of the university, for his constructive criticisms during the preparation of this paper.*

[1] Talcott Parsons, "The Professions and Social Structure," *Social Forces*, Vol. 17 (May 1939), pp. 457–467.

[2] Theodore Caplow, *The Sociology of Work* (Minneapolis: University of Minnesota Press, 1954).

[3] Oswald Hall, "The Stages of a Medical Career," *American Journal of Sociology*, Vol. 53 (March 1948), pp. 327–336; "Types of Medical Careers," *American Journal of Sociology*, Vol. 55 (November 1949), pp. 243–253; "Sociological Research in the Field of Medicine: Progress and Prospects," *American Sociological Review*, Vol. 16 (October 1951), pp. 639–644.

[4] U. S. Bureau of the Census, *1950 Census of Population: Classified Index of Occupations and Industries* (Washington, D. C.: Government Printing Office, 1950).

[5] The writer acknowledges his debt to his former students at the School of Social Welfare, University of California, Berkeley, who, as members of his research seminars, assisted him in identifying and abstracting the sociological literature on occupations. Their conscientious assistance made possible the formulation presented in this paper.

true difference between a professional and a nonprofessional occupation is not a qualitative but a quantitative one. Strictly speaking, these attributes are not the exclusive monopoly of the professions; nonprofessional occupations also possess them, but to a lesser degree. As is true of most social phenomena, the phenomenon of professionalism cannot be structured in terms of clear-cut classes. Rather, we must think of the occupations in a society as distributing themselves along a continuum.[6] At one end of this continuum are bunched the well-recognized and undisputed professions (*e.g.*, physician, attorney, professor, scientist); at the opposite end are bunched the least skilled and least attractive occupations (*e.g.*, watchman, truckloader, farm laborer, scrubwoman, bus boy). The remaining occupations, less skilled and less prestigeful than the former, but more so than the latter, are distributed between these two poles. The occupations bunched at the professional pole of the continuum possess to a maximum degree the attributes about to be described. As we move away from this pole, the occupations possess these attributes to a decreasing degree. Thus, in the less developed professions, social work among them, these attributes appear in moderate degree. When we reach the mid-region of the continuum, among the clerical, sales, and crafts occupations, they occur in still lesser degree; while at the unskilled end of the continuum the occupations possess these attributes so minimally that they are virtually nonexistent. If the reader keeps this concept of the continuum in mind, the presentation will less likely appear as a distortion of reality.

[6] The occupational classification employed by the U. S. Census Bureau is precisely such a continuum. The categories of this classification are: (a) professionals and semiprofessional technical workers; (b) proprietors and managers, both farm and nonfarm, and officials; (c) clerical, sales, and kindred workers; (d) craftsmen, skilled workers, and foremen; (e) operatives and semiskilled workers; and (e) laborers, unskilled, service, and domestic workers. (U. S. Bureau of the Census, *op. cit.*).

SYSTEMATIC BODY OF THEORY[7]

It is often contended that the chief difference between a professional and a nonprofessional occupation lies in the element of superior skill. The performance of a professional service presumably involves a series of unusually complicated operations, mastery of which requires lengthy training. The models referred to in this connection are the performances of a surgeon, a concert pianist, or a research physicist. However, some nonprofessional occupations actually involve a higher order of skill than many professional ones. For example, tool-and-die making, diamond-cutting, monument-engraving, or cabinet-making involve more intricate operations than schoolteaching, nursing, or social work. Therefore, to focus on the element of skill per se in describing the professions is to miss the kernel of their uniqueness.

The crucial distinction is this: the skills that characterize a profession flow from and are supported by a fund of knowledge that has been organized into an internally consistent system, called a *body of theory*. A profession's underlying body of theory is a system of abstract propositions that describe in general terms the classes of phenomena comprising the profession's focus of interest. Theory serves as a base in terms of which the professional rationalizes his operations in concrete situations. Acquisition of the professional skill requires a prior or simultaneous mastery of the theory underlying that skill. Preparation for a profession, therefore, involves considerable preoccupation with systematic theory, a feature virtually absent in the training of the nonprofessional. And so treatises are written on legal theory, musical theory, social work theory, the theory of the drama, and so on; but no books appear on the theory of punch-pressing or pipe-fitting or bricklaying.

[7] The sequence in which the five attributes are discussed in this paper does not reflect upon their relative importance. The order selected has been dictated by logical considerations.

Because understanding of theory is so important to professional skill, preparation for a profession must be an intellectual as well as a practical experience. On-the-job training through apprenticeship, which suffices for a nonprofessional occupation, becomes inadequate for a profession. Orientation in theory can be achieved best through formal education in an academic setting. Hence the appearance of the professional school, more often than not university affiliated, wherein the milieu is a contrast to that of the trade school. Theoretical knowledge is more difficult to master than operational procedures; it is easier to learn to repair an automobile than to learn the principles of the internal combustion engine. There are, of course, a number of free-lance professional pursuits (*e.g.*, acting, painting, writing, composing, and the like) wherein academic preparation is not mandatory. Nevertheless, even in these fields various "schools" and "institutes" are appearing, although they may not be run along traditional academic lines. We can generalize that as an occupation moves toward professional status, apprenticeship training yields to formalized education, because the function of theory as a groundwork for practice acquires increasing importance.

The importance of theory precipitates a form of activity normally not encountered in a nonprofessional occupation, *viz.*, theory construction via systematic research. To generate valid theory that will provide a solid base for professional techniques requires the application of the scientific method to the service-related problems of the profession. Continued employment of the scientific method is nurtured by and in turn reinforces the element of *rationality*.[8] As an orientation, rationality is the antithesis of traditionalism. The spirit of rationality in a profession encourages a critical, as opposed to a reverential, attitude toward the theoretical system. It implies a perpetual readiness to discard any portion of that system, no matter how time honored it may be, with a formulation demonstrated to be more valid. The spirit of rationality generates group self-criticism and theoretical controversy. Professional members convene regularly in their associations to learn and to evaluate innovations in theory. This produces an intellectually stimulating milieu that is in marked contrast to the milieu of a nonprofessional occupation.

In the evolution of every profession there emerges the researcher-theoretician whose role is that of scientific investigation and theoretical systematization. In technological professions[9] a division of labor thereby evolves, that between the theory-oriented and the practice-oriented person. Witness the physician who prefers to attach himself to a medical research center rather than to enter private practice. This division may also yield to cleavages with repercussions upon intraprofessional relationships. However, if properly integrated, the division of labor produces an accelerated expansion of the body of theory and a sprouting of theoretical branches around which specialties nucleate. The net effect of such developments is to lengthen the preparation deemed desirable for entry into the profession. This accounts for the rise of graduate professional training on top of a basic college education.

PROFESSIONAL AUTHORITY

Extensive education in the systematic theory of his discipline imparts to the professional a type of knowledge that highlights the layman's comparative ignorance. This fact is the basis for the professional's authority, which has some interesting features.

A nonprofessional occupation has cus-

[8] Parsons, *op. cit.*

[9] A technology is a profession whose aim is to achieve controlled changes in natural relationships. Convention makes a distinction between technologists who shape nonhuman materials and those who deal with human beings. The former are called engineers; the latter practitioners.

tomers; a professional occupation has clients. What is the difference? A customer determines what services and/or commodities he wants, and he shops around until he finds them. His freedom of decision rests upon the premise that he has the capacity to appraise his own needs and to judge the potential of the service or of the commodity to satisfy them. The infallibility of his decisions is epitomized in the slogan: "The customer is always right!" In a professional relationship, however, the professional dictates what is good or evil for the client, who has no choice but to accede to professional judgment. Here the premise is that, because he lacks the requisite theoretical background, the client cannot diagnose his own needs or discriminate among the range of possibilities for meeting them. Nor is the client considered able to evaluate the caliber of the professional service he receives. In a nonprofessional occupation the customer can criticize the quality of the commodity he has purchased, and even demand a refund. The client lacks this same prerogative, having surrendered it to professional authority. This element of authority is one, although not the sole, reason why a profession frowns on advertising. If a profession were to advertise, it would, in effect, impute to the potential client the discriminating capacity to select from competing forms of service. The client's subordination to professional authority invests the professional with a monopoly of judgment. When an occupation strives toward professionalization, one of its aspirations is to acquire this monopoly.

The client derives a sense of security from the professional's assumption of authority. The authoritative air of the professional is a principal source of the client's faith that the relationship he is about to enter contains the potentials for meeting his needs. The professional's authority, however, is not limitless; its function is confined to those specific spheres within which the professional has been educated. This quality in professional authority Parsons calls *functional specificity*.[10] Functional specificity carries the following implications for the client-professional relationship.

The professional cannot prescribe guides for facets of the client's life where his theoretical competence does not apply. To venture such prescriptions is to invade a province wherein he himself is a layman, and, hence, to violate the authority of another professional group. The professional must not use his position of authority to exploit the client for purposes of personal gratification. In any association of superordination-subordination, of which the professional-client relationship is a perfect specimen, the subordinate member—here, the client—can be maneuvered into a dependent role. The psychological advantage which thereby accrues to the professional could constitute a temptation for him. The professional must inhibit his impulses to use the professional relationship for the satisfaction of the sexual need, the need to manipulate others, or the need to live vicariously. In the case of the therapeutic professions it is ideally preferred that client-professional intercourse not overflow the professional setting. Extraprofessional intercourse could be used by both client and professional in a manner such as to impair professional authority, with a consequent diminution of the professional's effectiveness.

Thus far we have discussed that phase of professional authority which expresses itself in the client-professional relationship. Professional authority, however, has professional-community ramifications. To these we now turn.

SANCTION OF THE COMMUNITY

Every profession strives to persuade the community to sanction its authority within certain spheres by conferring upon the profession a series of powers and privileges. Community approval of these powers and privileges may be either informal or formal; formal approval is that reinforced by the community's police power.

[10] Parsons, *op. cit.*

Among its powers is the profession's control over its training centers. This is achieved through an accrediting process exercised by one of the associations within the profession. By granting or withholding accreditation, a profession can, ideally, regulate its schools as to their number, location, curriculum content, and caliber of instruction. Comparable control is not to be found in a nonprofessional occupation.[11] The profession also acquires control over admission into the profession. This is achieved via two routes. First, the profession convinces the community that no one should be allowed to wear a professional title who has not been conferred it by an accredited professional school. Anyone can call himself a carpenter, locksmith, or metal-plater if he feels so qualified. But a person who assumes the title of physician or attorney without having earned it conventionally becomes an impostor. Secondly, the profession persuades the community to institute in its behalf a licensing system for screening those qualified to practice the professional skill. A *sine qua non* for the receipt of the license is, of course, a duly granted professional title. Another prerequisite may be an examination before a board of inquiry whose personnel have been drawn from the ranks of the profession. Police power enforces the licensing system; persons practicing the professional skill without a license are liable to punishment by public authority.[12]

Among the professional privileges, one of the most important is that of confidentiality. To facilitate efficient performance, the professional encourages the client to volunteer information he otherwise would not divulge. The community regards this as privileged communication, shared solely between client and professional, and protects the latter legally from encroachments upon such confidentiality. To be sure, only a select few of the professions, notably medicine and law, enjoy this immunity. Its very rarity makes it the ultimate in professionalization. Another one of the professional privileges is a relative immunity from community judgment on technical matters. Standards for professional performance are reached by consensus within the profession and are based on the existing body of theory. The lay community is presumed incapable of comprehending these standards and, hence, of using them to identify malpractice. It is generally conceded that a professional's performance can be evaluated only by his peers.

The powers and privileges described above constitute a monopoly granted by the community to the professional group. Therefore, when an occupation strives toward professional status, one of its prime objectives is to acquire this monopoly. But this is difficult to achieve, because counter forces within the community resist strongly the profession's claims to authority. Through its associations the profession wages an organized campaign to persuade the community that it will benefit greatly by granting the monopoly. Specifically the profession seeks to prove: that the performance of the occupational skill requires specialized education; that those who possess this education, in contrast to those who do not, deliver a superior service; and that the human need being served is of sufficient social importance to justify the superior performance.

REGULATIVE CODE OF ETHICS

The monopoly enjoyed by a profession vis-à-vis clients and community is fraught with hazards. A monopoly can be abused;

---

[11] To set up and run a school for floral decorating requires no approval from the national florists' association, but no school of social work could operate long without approval of the Council on Social Work Education.

[12] Many nonprofessional occupations have also succeeded in obtaining licensing legislation in their behalf. Witness the plumbers, radio operators, and barbers, to mention a few. However, the sanctions applied against a person practicing a nonprofessional occupation are much less severe than is the case when a professional occupation is similarly involved.

powers and privileges can be used to protect vested interests against the public weal.[13] The professional group could peg the price of its services at an unreasonably high level; it could restrict the numbers entering the occupation to create a scarcity of personnel; it could dilute the caliber of its performance without community awareness; and it could frustrate forces within the occupation pushing for socially beneficial changes in practices.[14] Were such abuses to become conspicuous, widespread, and permanent, the community would, of course, revoke the profession's monopoly. This extreme measure is normally unnecessary, because every profession has a built-in regulative code which compels ethical behavior on the part of its members.

The profession's ethical code is part formal and part informal. The formal is the written code to which the professional usually swears upon being admitted to practice; this is best exemplified by the Hippocratic Oath of the medical profession. The informal is the unwritten code, which nonetheless carries the weight of formal prescriptions. Through its ethical code the profession's commitment to the social welfare becomes a matter of public record, thereby insuring for itself the continued confidence of the community. Without such confidence the profession could not retain its monopoly. To be sure, self-regulative codes are characteristic of all occupations, nonprofessional as well as professional. However, a professional code is perhaps more explicit, systematic, and binding; it certainly possesses more altruistic overtones and is more public service-oriented.[15] These account for the frequent synonymous use of the terms "professional" and "ethical" when applied to occupational behavior.

While the specifics of their ethical codes vary among the professions, the essentials are uniform. These may be described in terms of client-professional and colleague-colleague relations.

Toward the client the professional must assume an emotional neutrality. He must provide service to whoever requests it, irrespective of the requesting client's age, income, kinship, politics, race, religion, sex, and social status. A nonprofessional may withhold his services on such grounds without, or with minor, censure; a professional cannot. Parsons calls this element in professional conduct *universalism*. In other words, only in his extraoccupational contacts can the professional relate to others on particularistic terms, *i.e.*, as particular individuals with concrete personalities attractive or unattractive to him. In his client contacts particularistic considerations are out of place. Parsons also calls attention to the element of *disinterestedness* in the professional-client relationship.[16] In contrast to the nonprofessional, the professional is motivated less by self-interest and more by the impulse to perform maximally. The behavior corollaries of this service orientation are many. For one, the professional must, under all circumstances, give maximum caliber service. The nonprofessional can dilute the quality of his commodity or service to fit the size of the client's fee; not so the professional. Again, the professional must be prepared to render his services upon request, even at the sacrifice of personal convenience.

The ethics governing colleague relationships demand behavior that is co-operative, equalitarian, and supportive. Members of a profession share technical knowledge with each other. Any advance in theory and practice made by one professional is quickly disseminated to colleagues through the pro-

[13] Abraham Flexner, "Is Social Work a Profession?" in *Proceedings of the National Conference of Charities and Corrections* (Chicago: 1915), pp. 576–590.

Robert K. Merton, "Bureaucratic Structure and Personality," in Alvin Gouldner, ed., *Studies in Leadership* (New York: Harper & Brothers, 1950), pp. 67–79.

[14] Merton, *op. cit.*

[15] Flexner, *op. cit.* Parsons, *op. cit.*

[16] Parsons, *op. cit.*

fessional associations.[17] The proprietary and quasi-secretive attitudes toward discovery and invention prevalent in the industrial and commercial world are out of place in the professional. Also out of place is the blatant competition for clients which is the norm in so many nonprofessional pursuits. This is not to gainsay the existence of intraprofessional competition; but it is a highly regulated competition, diluted with co-operative ingredients which impart to it its characteristically restrained quality. Colleague relations must be equalitarian; intraprofessional recognition should ideally be based solely upon performance in practice and/or contribution to theory.[18] Here, too, particularistic considerations must not be allowed to operate. Finally, professional colleagues must support each other vis-à-vis clientele and community. The professional must refrain from acts which jeopardize the authority of colleagues, and must sustain those whose authority is threatened.[19]

The ways and means whereby a profession enforces the observance of its ethical code constitute a case study in social control. Self-discipline is achieved informally and formally.

Informal discipline consists of the subtle and the not-so-subtle pressures that colleagues exert upon one another. An example in this connection is the phenomenon of consultation and referral.[20] Consultation is the practice of inviting a colleague to participate in the appraisal of the client's need and/or in the planning of the service to be rendered. Referral is the practice of affording colleagues access to a client or an appointment. Thus, one colleague may refer his client to another, because lack of time or skill prevents his rendering the needed service; or he may recommend another for appointment by a prospective employer. Since professional ethics precludes aggressive competition and advertising, consultation and referral constitute the principal source of work to a professional. The consultation-referral custom involves professional colleagues in a system of reciprocity which fosters mutual interdependence. Interdependence facilitates social control; chronic violation of professional etiquette arouses colleague resentment, resulting in the cessation of consultation requests and referrals.

A more formal discipline is exercised by the professional associations, which possess the power to criticize or to censure, and in extreme cases to bar recalcitrants. Since membership in good standing in the professional associations is a *sine qua non* of professional success, the prospect of formal disciplinary action operates as a potent force toward conformity.

THE PROFESSIONAL CULTURE

Every profession operates through a network of formal and informal groups. Among the formal groups, first there are the organizations through which the profession performs its services; these provide the institutionalized setting where professional and client meet. Examples of such organizations are hospital, clinic, university, law office, engineering firm, or social agency. Secondly, there are the organizations whose functions are to replenish the profession's supply of talent and to expand its fund of knowledge. These include the educational and the research centers. Third among the formal groups are the organizations which emerge as an expression of the growing consciousness-of-kind on the part of the profession's members, and which promote so-called group interests and aims. These are the professional associations. Within and around these formal organizations extends a filigree of informal group-

[17] Arlien Johnson, "Professional Standards and How They Are Attained," *Journal of American Dental Association*, Vol. 31 (September 1944), pp. 1181–1189.

[18] Flexner, *op. cit.*

[19] This partly explains why physicians do not testify against each other in malpractice suits.

[20] Hall, *op. cit.*

ings: the multitude of small, closely knit clusters of colleagues. Membership in these cliques is based on a variety of affinities: specialties within the profession; affiliations with select professional societies; residential and work propinquity; family, religious, or ethnic background; and personality attractions.

The interactions of social roles required by these formal and informal groups generate a social configuration unique to the profession, *viz.*, a professional culture. All occupations are characterized by formal and informal groupings; in this respect the professions are not unique. What is unique is the culture thus begotten. If one were to single out the attribute that most effectively differentiates the professions from other occupations, this is it. Thus we can talk of a professional culture as distinct from a nonprofessional culture. Within the professions as a logical class each profession develops its own subculture, a variant of the professional culture; the engineering subculture, for example, differs from the subcultures of medicine and social work. In the subsequent discussion, however, we will treat the culture of the professions as a generic phenonemon. The culture of a profession consists of its *values, norms,* and *symbols.*

The social values of a professional group are its basic and fundamental beliefs, the unquestioned premises upon which its very existence rests. Foremost among these values is the essential worth of the service which the professional group extends to the community. The profession considers that the service is a social good and that community welfare would be immeasurably impaired by its absence. The twin concepts of professional authority and monopoly also possess the force of a group value. Thus, the proposition that in all service-related matters the professional group is infinitely wiser than the laity is regarded as beyond argument. Likewise nonarguable is the proposition that acquisition by the professional group of a service monoply would inevitably produce social progress. And then there is the value of rationality; that is, the commitment to objectivity in the realm of theory and technique. By virtue of this orientation, nothing of a theoretical or technical nature is regarded as sacred and unchallengeable simply because it has a history of acceptance and use.

The norms of a professional group are the guides to behavior in social situations. Every profession develops an elaborate system of these role definitions. There is a range of appropriate behaviors for seeking admittance into the profession, for gaining entry into its formal and informal groups, and for progressing within the occupation's hierarchy. There are appropriate modes of securing appointments, of conducting referrals, and of handling consultation. There are proper ways of acquiring clients, of receiving and dismissing them, of questioning and treating them, of accepting and rejecting them. There are correct ways of grooming a protégé, of recompensing a sponsor, and of relating to peers, superiors, or subordinates. There are even group-approved ways of challenging an outmoded theory, of introducing a new technique, and of conducting an intra-professional controversy. In short, there is a behavior norm covering every standard interpersonal situation likely to recur in professional life.

The symbols of a profession are its meaning-laden items. These may include such things as: its insignias, emblems, and distinctive dress; its history, folklore, and argot; its heroes and its villains; and its stereotypes of the professional, the client, and the layman.

Comparatively clear and controlling group values, behavior norms, and symbols, which characterize the professions, are not to be encountered in nonprofessional occupations.

Our discussion of the professional culture would be incomplete without brief men-

tion of one of its central concepts, the *career* concept. The term career is, as a rule, employed only in reference to a professional occupation. Thus, we do not talk about the career of a bricklayer or of a mechanic; but we do talk about the career of an architect or of a clergyman. At the heart of the career concept is a certain attitude toward work which is peculiarly professional. A career is essentially a *calling*, a life devoted to "good works."[21] Professional work is never viewed solely as a means to an end; it is the end itself. Curing the ill, educating the young, advancing science are values in themselves. The professional performs his services primarily for the psychic satisfactions and secondarily for the monetary compensations.[22] Self-seeking motives feature minimally in the choice of a profession; of maximal importance is affinity for the work. It is this devotion to the work itself which imparts to professional activity the service orientation and the element of disinterestedness. Furthermore, the absorption in the work is not partial, but complete; it results in a total personal involvement. The work life invades the after-work life, and the sharp demarcation between the work hours and the leisure hours disappears. To the professional person his work becomes his life.[23] Hence the act of embarking upon a professional career is similar in some respects to entering a religious order. The same cannot be said of a nonprofessional occupation.

To succeed in his chosen profession, the neophyte must make an effective adjustment to the professional culture.[24] Mastery of the underlying body of theory and acquisition of the technical skills are in themselves insufficient guarantees of professional success. The recruit must also become familiar with and learn to weave his way through the labyrinth of the professional culture. Therefore, the transformation of a neophyte into a professional is essentially an acculturation process wherein he internalizes the social values, the behavior norms, and the symbols of the occupational group.[25] In its frustrations and rewards it is fundamentally no different from the acculturation of an immigrant to a relatively strange culture. Every profession entertains a stereotype of the ideal colleague; and, of course, it is always one who is thoroughly adjusted to the professional culture.[26] The poorly acculturated colleague is a deviant; he is regarded as "peculiar," "unorthodox," "an-

[21] The term *calling* literally means a divine summons to undertake a course of action. Originally, it was employed to refer to religious activity. The Protestant Reformation widened its meaning to include economic activity as well. Henceforth divinely inspired "good works" were to be both secular and sacred in nature. Presumably, then, any occupational choice may be a response to divine summons. In this connection, it is interesting to note that the German word for vocation is *Beruf*, a noun derived from the verb *berufen*, to call.

[22] Johnson, *op. cit.*

[23] The all-pervading influence of work upon the lives of professionals results in interesting by-products. The members of a profession tend to associate with one another outside the work setting (Oswald Hall, "The Stages of a Medical Career," *op. cit.*). Their families mingle socially; leisure time is spent together; "shop talk" permeates social discourse; and a consensus develops. The profession thus becomes a whole social environment, nurturing characteristic social and political attitudes, patterns of consumption and recreation, and decorum and *Weltanschauung* (Caplow, *op. cit.;* and William H. Form, "Toward an Occupational Social Psychology," *Journal of Social Psychology*, Vol. 24, February 1946, pp. 85–99).

[24] Oswald Hall, "The Stages of a Medical Career" and "Types of Medical Careers," *op. cit.*

[25] R. Clyde White, " 'Social Workers in Society': Some Further Evidence," *Social Work Journal*, Vol. 34 (October 1953), pp. 161–164.

[26] The laity also entertain a stereotypic image of the professional group. Needless to say, the layman's conception and the professional's self-conception diverge widely, because they are fabricated out of very different experiences. The layman's stereotype is frequently a distortion of reality, being either an idealization or a caricature of the professional type.

noying," and in extreme cases a "troublemaker." Whereas the professional group encourages innovation in theory and technique, it tends to discourage deviation from its social values and norms. In this internal contradiction, however, the professional culture is no different from the larger culture of society.

One of the principal functions of the professional schools is to identify and screen individuals who are prospective deviants from the professional culture. That is why the admission of candidates to professional education must be judged on grounds in addition to and other than their academic qualifications.[27] Psychic factors presaging favorable adjustment to the professional culture are granted an importance equivalent to mental abilities. The professional school provides test situations through initial and graduated exposures of the novice to the professional culture. By his behavior in these social situations involving colleagues, clients, and community, the potential deviant soon reveals himself and is immediately weeded out. Comparable preoccupation with the psychic prerequisites of occupational adjustment is not characteristic of nonprofessional occupations.

IMPLICATIONS FOR SOCIAL WORK

The picture of the professions just unveiled is an ideal type. In the construction of an ideal type some exaggeration of reality is unavoidable, since the intent is to achieve an internally coherent picture. One function of the ideal type is to structure reality in such manner that discrete, disparate, and dissimilar phenomena become organized, thereby bringing order out of apparent disorder. We now possess a model of a profession that is much sharper and clearer than the actuality that confronts us when we observe the occupational scene. What is the utility of this model for social work?

The preoccupation of social workers with professionalization has been a characteristic feature of the social work scene for years. Flexner,[28] Johnson,[29] Hollis and Taylor,[30] and others have written on the subject, proposing criteria which must be met if social work is to acquire professional status. Whenever social workers convene, there is the constant reaffirmation of the urgency to achieve the recognition from the community befitting a profession. The union of the seven separate organizations into the National Association of Social Workers is generally regarded as an important milestone in social work history, precisely because of its potential stimulus toward professionalization.

In view of all this, it is proper for social workers to possess clear conceptions of that which they so fervently seek. The model of the professions portrayed above should contribute to such clarification; it should illuminate the goal for which social workers are striving. It is often contended that social work is still far from having attained professional status.[31] But this is a misconception. When we hold up social work against the model of the professions presented above, it does not take long to decide whether to classify it within the professional or the nonprofessional occupations. Social work is already a profession; it has too many points of congruence with the model to be classifiable otherwise. Social work is, however, seeking to rise within the professional hierarchy, so that it, too, might enjoy maximum prestige, authority, and monopoly which presently belong to a few top professions.

---

[27] Oswald Hall, "Sociological Research in the Field of Medicine: Progress and Prospects," *op. cit.*

[28] Flexner, *op. cit.*

[29] Johnson, *op. cit.*

[30] Ernest V. Hollis and Alice L. Taylor, *Social Work Education in the United States* (New York: Columbia University Press, 1951).

[31] Flexner considered that the social work of his day was not a profession. Hollis and Taylor regard present-day social work as still in its early adolescence.

The model presented above should also serve to sensitize social workers to anticipate some of the problems that continued professionalization must inevitably precipitate. The model indicates that progressive professionalization will involve social workers in novel relationships with clients, colleagues, agency, community, and other professions. In concluding this paper we refer briefly to one such problem. It is no secret that social workers are not all uniformly enthusiastic about the professionalization of social work. Bisno [32] has given verbalization to a prevailing apprehension that social workers might have to scuttle their social-action heritage as a price of achieving the public acceptance accorded a profession. Extrapolation from the sociologists' model of the professions suggests a reality basis for these fears. It suggests that the attainment of professional prestige, authority, and monopoly by social workers will undoubtedly carry disturbing implications for the social action and social reform components of social work philosophy. The anticipated developments will compel social workers to rethink and redefine the societal role of their profession.

These and other dilemmas flowing from professionalization are bound to tax the best minds among social workers for their resolution. In this connection a proper understanding of the attributes of a profession would seem to be indispensable.

[32] Herbert Bisno, "How Social Will Social Work Be?" *Social Work*, Vol. 1, No. 2 (April 1956), pp. 12–18.

GROUP WORK SECTION

BY ROBERT R. WOODRUFF

Group Work in a Children's Hospital

As A MEMBER of an interdisciplinary team in a children's hospital, the writer has been able to observe the reactions of children to hospitalization and to appreciate their feelings and needs. He has observed their reactions to the experience of hospitalization and treatment for illness as being distinct from the effect of the illness itself. These reactions call for strenuous methods of treatment, taxing the skills of all members of the team, particularly for children of preschool age where separation from parents plays a major role and for those with limited capacities to adapt.[1]

The hospital has an ambitious, organized recreation program under a recreation director designed to provide play outlets for children. Gray Ladies and play nurses in training, birthdays, holidays, special events, weekly features, and day-to-day game periods are all used in the recreation program. Ward play rooms stocked with toys and reading materials for the ambulatory, handicraft and music appreciation periods provided in conjunction with the hospital and school program, and rhythm bands round out the program. It is a far-reaching program both in scope and coverage, but represents only one step in helping hospitalized children achieve an optimum institutional adjustment. One important step, the writer believes, in this direction would be the addition of a professionally trained group worker to the interdisciplinary team.

Although deep-seated traumatic effects of an emotional nature do not arise with every hospitalization, the possibility appears to be great enough to justify the use of all possible prophylactic measures. Social group workers are needed on the staff of a hospital to help children maintain and achieve their rightful potential. Their keen awareness of children's feelings toward hospitalization is essential to constructive work with them.

The literature on this subject is virtually unanimous in characterizing hospitalization as an involuntary, dreaded event in

ROBERT R. WOODRUFF, M.S.W., *is district supervisor of home and school visitors, Division of Guidance and Child Accounting, in the Pittsburgh public school system. This paper was originally prepared for a course requirement when the author was a student psychiatric social worker with a field placement at the Children's Hospital of Pittsburgh.*

[1] Dana G. Prugh, Elizabeth M. Staub, Harriet H. Sands, Ruth Kirschbaum, and Ellenora A. Lenihan, "A Study of the Emotional Reactions of Children and Families to Hospitalization and Illness," *American Journal of Orthopsychiatry,* Vol. 23 (January 1953), p. 103.

EDITOR'S NOTE: This article and the three following it were chosen by the Publications Committees of the indicated Sections of NASW in accordance with a policy approved by the National Board of Directors.

the minds of children. Jackson points out that two essential conditions give rise to neurotic anxiety: (1) situations in which the child becomes insecure because he fears the loss of a love object or those upon whom he is dependent; and (2) situations in which he risks the possibility of injury, particularly at the hands of some other human being.[2] The dynamics of castration fears are readily evident in this latter area.

To children who have been hospitalized without adequate preparation or by trickery, the idea of abandonment, rejection, and punishment is strong, particularly since the child becomes aware that parental permission is given for painful treatment or operative procedures. Many other emotional problems also face children who are hospitalized, for example:

1. Fear of separation from parents and home, possibly for the first time.
2. Loss of freedom and privacy in strange surroundings and in intimate contact with strange children and adults.
3. Feelings about loss of independence that has been gained, which results in regression in most instances.
4. Fearful reactions to injections, anesthesia, and other new, painful, or strange experiences.
5. Overwhelming pain and anxiety related to illness.[3]

Recreation is not the sole answer to the needs of children experiencing such problems. The child must be viewed as a whole, with his family backgrounds and cultural patterns, and particularly in the light of the meaning of his illness for him. The group worker seeks to understand the child's needs and to help him with his problems through group experiences. Each hospital ward, as a small social world of its own, is a setting in which the worker can help the patient discharge tensions in a conducive atmosphere. The group worker recognizes the distinctive elements in the personality of hospitalized children as they adapt themselves to the problems of separation from family, frustration of illness, and the strange environment of the hospital. The group is used by the worker to help children accept hospitalization better and to work through their feelings of anxiety.

Allbee cites the value of group experience for the hospitalized child in the following terms:

> The chief values group work can offer hospitalized children are reassurance and the opportunity to discharge tension in an atmosphere that is permissive and non-threatening. Reassurances that these children can give each other are far beyond those that can be given by an adult, whose help, no matter how well meaning, often appears as a new threat. As good as a relationship can be between children and adults, significant and understanding communication from one child to another carries greater weight.[4]

The group has value in providing a setting for the expression of fears and anxieties that might ordinarily be repressed within the structure of a near-family group. Patients thus help each other distinguish between fantasy and reality in a fashion that is acceptable from a peer group yet does not carry the threat of an authoritative figure. This is a two-way process in that the patient giving help achieves status and a feeling of importance, and the patient receiving help responds to the in-

---

[2] Edith B. Jackson, "Treatment of the Young Child in the Hospital," *American Journal of Orthopsychiatry*, Vol. 12 (January 1942), p. 56.

[3] Grace L. Coyle and Raymond Fisher, "Helping Hospitalized Children Through Social Group Work," *The Child*, Vol. 16 (April 1952), p. 115.

Constance I. Allbee, "Group Work With Hospitalized Children," *Children*, Vol. 6 (November–December 1955), p. 287.

Constance Impallaria, "Some Contributions of Therapeutic Group Work in a Medical Setting," in *Selected Papers in Group Work and Community Organization* (Raleigh, N. C.: Health Publications Institute, 1952), p. 56.

[4] Allbee, *op. cit.*, p. 221.

terest shown in him and uses the help offered.[5]

The group worker must be consciously aware of his function in order to bring specific help to those patients.

FUNCTION OF THE GROUP WORKER

Coyle and Fisher state the function of the group worker as follows:

> . . . to help individuals, by means of guided group experience, to develop and use their capacities for personally satisfying social relationships; to help them to deal with the problems presented by their environment and to use the resources of this environment in a constructive way. As a result of these positive, progressive experiences the persons who take part in them are enabled to carry more effectively their responsibilities in a democratic society.[6]

The hospitalized child is confronted not only with the experience of pain but also finds himself in a new and strange atmosphere. The group worker acts to bring these feelings out into the open where they can be dealt with, and the child who benefits most is the one who makes the transition from a passive, compliant role to a more active, aggressive one. The worker must use his understanding of the meaning of subgroups to children, the roles of leaders and followers, of the isolates and the heroes, the reactions of children to authority.

The skill of the group worker to contribute to the patient's movement toward recovery lies in three major areas: (1) accepting and working with the individual patient; (2) working with the group; and (3) developing suitable program.[7]

The worker must understand the meaning of his role to the patient, to know whether the child sees him as a substitute parent, a means of escape, a source of pleasure, or an interpreter of hospital restrictions. Knowing this, he is then prepared to react appropriately to children's feelings of hostility, overenthusiasm, indifference, suspicion, or acceptance.

Intake and participation. In a hospital setting where the composition of the group is flexible and without stringent criteria, intake for the group is a logical function for the group worker. Recognizing the right of the individual to participate in decision-making, the group worker contacts the new patient on one or more occasions, may casually invite or urge him to join the group, may lead him by the hand or enable him to come on his own. The approach here depends on the age of the child, his mobility, and an assessment of anticipated reaction gained from interchange with other ward personnel who have observed the child.

From the outset, the relationship with the patient is a supportive one, geared to help the child become a part of the group, and the worker uses his knowledge of the child's interests and potential to help establish a bond. Various aspects of programming, including cultural, recreational, and informal educational activities, are interpreted with a strong emphasis on the fact that the patient's participation in planning and carrying out program is both welcome and desirable. This intake interview, so to speak, also serves to reveal some of the surface feelings that might be a threat to the patient.[8] These activities are designed to make the patient an active participant in his new environment and achieve satisfying relationships. In the authoritative setting of the hospital, the decision to par-

---

[5] Raymond Fisher, "Group Work in Specialized Settings," in *Group Work Foundations and Frontiers* (New York: Whiteside, 1955), p. 201.

[6] Coyle and Fisher, *op. cit.*, p. 114.

[7] Maree Brower, "Encouraging Initiative in Convalescent Children," *The Child*, Vol. 15 (October 1950), p. 197.

[8] C. G. Gifford, E. E. Landis, and S. Spafford Ackerly, "The Use of Social Group Work as a Therapeutic Factor in the Hospital Setting," *American Journal of Orthopsychiatry*, Vol. 23 (January 1953), p. 149.

ticipate in a group is one of the few choices offered a patient.

Readiness for group participation is difficult to assess without actual exposure to the group which gives the worker the opportunity to diagnose the situation. In addition, there is patient turnover resulting in constant change in membership and status and cohesion fluctuations. Depending upon the contribution of which he is capable, the patient may be introduced to the group on an observer level, gradually engage in superficial participation, and eventually participate on a full planning-sharing level.

The selection of the appropriate ward group for the child is also important. Through information gained from ward conferences and individual meetings with the child, suitable placement can be effected that will result in emotionally satisfying relationships. Not only should placement be based on age, sex, and disease, but there should also be consideration of how he will fit into the ongoing group; a new patient could ruin a harmonious group or be subjected to scapegoat treatment.

Realizing that small groups are most fruitful, the worker strategically places children with prior introductions and with beds, carts, and wheelchairs in the group situation so that their awareness of one another will be enhanced.

PROGRAM SKILLS

The group worker modifies his use of techniques and tools to meet the requirements of the hospital setting. In this setting, he must have a more intensive acquaintance with medical and psychiatric knowledge than is required for practice in primary settings as well as the capacity to accept mental and emotional illness and to work with it. He also emphasizes individualization, with relatively less emphasis on the group's achievement.

Timing of program is important. While there is need for group activity during the day, this period is also filled with the hospital school program, the hum of the daily routine, and parent visits. The loneliest time of day for the patient, on the other hand, is after the evening meal and before bedtime when nostalgic and separation feelings are highest. Personnel who do "to" and "for" the patient are withdrawing during this period, and the patient misses the time at home as a family member. A group, consciously formed, utilizing the common bonds of illness, enables the worker to use the parental role in which the children cast him and thus to recreate a parent-sibling situation.

The focus of program is the development of the patient's relationships; identification with the group; enjoyment, appreciation, and support of one another; the chance to develop his relationships during his confinement.

The program media used and group composition are based on the patient's personality organization, level of performance, and potentialities of achievement. Adaptations in use of arts, crafts, music, games, discussions, and dramatics are required. For example, arts and crafts may be used on an individual basis during the active period of the day, during the period of ward care and ward rounds which are prime functions of medical care. Finger-painting to music, discussions, and dramatics afford desirable media for acting out anxieties regarding needles, surgery, or separation.

Group discussion is a means of relieving anxiety. On a surgical ward, for instance, where anxieties are less on the surface than on a medical ward, to avoid repression of feelings it is desirable for a patient who has undergone a surgical experience to relive and master in a less traumatic way his original fears and worries. In so doing, he avoids repressed feelings, gains peer group recognition, and possibly status as an expert. Through such sharing of feelings, children get acceptance and support from each other.

The value of reversal of roles found in

role-playing, in which the passive patient becomes the powerful, controlling physician, is summarized by Allbee:

> In the warm non-threatening atmosphere of a group, children often *play out* or *talk out* their anxieties and fears about the whole experience of being in a hospital. The sick child's world is the hospital and the people in it are the important figures in his life. They are doctors and nurses, who may be friendly figures but who still can administer frightening and painful procedures, and other patients who come and go. Sometimes a child may regard anyone who comes in from the outside, even his own parents, with hostility. The group worker brings in reality through assisting some children in their various roles, discussing what the play can really mean, and in many subtle ways helping the children to discharge their anxieties safely.[9]

Coyle and Fisher further point out the use of newspapers as outlets for permanently handicapped adolescents to test capacities to be like nonhospitalized peers through writing about sports and love, for instance. The worker uses the concept of permissiveness through self-governing planning committees of children instead of authority, which sometimes provokes overtones of punishment and hostility.

The group worker consciously directs group experience for patients in the following manner:

1. Enables the group to support its members and gives this support himself.
2. Introduces limitations to the group although he does not assume an authoritative position.
3. Limits some patients through others or by himself.
4. Safeguards the needs of the group when the group is not prepared to protect itself.
5. Helps patients take small steps toward working through issues connected with their illness, either individually or in a group.
6. Involves the patients in thinking, working, and playing together.
7. Suggests activities when none are forthcoming from the group.
8. Encourages a maximum of free decision consistent with the safety of the patient and hospital policies.
9. Helps individual patients capitalize on their strengths and interests.
10. Helps the group capitalize on personality trends and the skills of its members.
11. Supports self-expression of patients.

[9] Allbee, *op. cit.*, pp. 219 ff.

WORK WITH PARENTS

Those who offer casework help within the hospital on a family-centered basis recognize that some parents of hospitalized children display certain affects whatever their children's adjustment on the ward. There may be realistic fear in proportion to the severity of the child's illness, overt anxiety, or guilt over involvement in causation of illness. Well-adjusted parents, on the other hand, are able to transfer their home relationships with the child, feeding him, playing with him, and putting him to bed.

In inadequately adjusted parents, the mechanisms of isolation, denial, and projection of guilt have been observed; and acting out sadistic impulses are not uncommon.

Group work has a contribution to make in working with parents of hospitalized children or children known on an outpatient basis. In a controlled group discussion, parents discussing common problems —caring for their sick child, posthospital treatment, and so on—can be quite supportive, and such discussion strengthens their efforts in helping their children toward recovery. This technique has been utilized with parents at well-baby clinics so effectively that problems which might otherwise have been repressed are brought to the surface and either discussed in the group or referred to examining physicians for individual conferences.

It is known, too, that children with func-

tional feeding disorders react favorably to hospitalization when the positive, concerted efforts of the hospital staff create a happy atmosphere which acts as a therapeutic agent for the child. Intrafamilial emotional stresses are usually the basis for such problems, and the patients somatize their rebellion to parental nagging through anorexia. Appropriate group work acceptance of such a child should speed the rapid disappearance of symptoms. Alert parents, seeing such dramatic unfolding of symptom causation, then begin to question their own methods at home and ask for help. This is an optimum setting for the beginning of treatment with parents, possibly on a referral basis to another member of the team, the medical social worker.

Indirect benefits of the group work program to parents are seen in the reassurance that parents gain from the knowledge that their child is with other youngsters and with a warm sympathetic adult.

STRUCTURE

In the hospital setting, the group worker functions in a secondary setting as one of many disciplines working in co-operation with the physician, the key person ultimately responsible for the patient's care. Group work services, as has already been pointed out, must be geared to those of the hospital. It is the physician, for instance, who gives clearance for a child's participation in a group and determines the degree of participation. The group worker, therefore, necessarily has to have the capacity to accept other professions yet be able, at the same time, to maintain his own identity and interpret it to others. While the function of stimulating group life is shared by all staff members, it is the group worker's assigned responsibility.

To perform this function, he is a member of the social service department and is a member of the team. As such he participates in weekly ward conferences as a means of exchanging information and making plans. In such conferences he contributes to the diagnostic thinking from his observations of group reactions of the patient. He may also function as a consultant in group situations involving administrators, doctors, nurses, therapists, and other social workers. The material provided the team from the group worker's recording is so dramatic as to be undeniable in making recommendations for regroupings of children, psychiatric referral, or other treatment plans including continuance in the group. In instances where intensive individual treatment is indicated outside the group or in conjunction with it, the worker makes appropriate referrals to other hospital personnel and to community social services.

CONCLUSIONS

The group worker contributes both to the diagnostic and the total therapeutic experiance of the hospitalized child. He makes a team contribution to a better understanding of the child, *e.g.,* as a whole person rather than a biological unit. Both patient and his parents are helped to accept hospital procedures, thus minimizing the traumatic effects of hospital experience and improving their morale. As a by-product of the positive group relationship in the hospital, the patient and his family may be encouraged to use other community resources after leaving the hospital.

MEDICAL SOCIAL WORK SECTION

BY HELEN REHR

Developing Casework Understanding with a Lay Committee

ONE OF THE problems that has concerned the social work profession has been how to interpret the skill and method of casework practice in terms that are meaningful to people outside the profession. One such group are the people who serve on committees connected with social service departments of hospitals and who give support to the casework program. This paper will describe a one-year experience in interpreting casework principles and practices to such a group, the case committee of the Women's Auxiliary Board of the Mount Sinai Hospital in New York City.

The Women's Auxiliary Board is the group to which the hospital's board of trustees has delegated the responsibility for recommending improvement in auxiliary patient services, *e.g.*, social service, use of volunteers, occupational therapy, recreation, and the patient library. Since a clear understanding of patients' individual needs is necessary to carry out this responsibility, it is not surprising that a case comitttee developed as an integral part of this group. Initially, the case committee was set up to receive requests for individual patient needs, *e.g.*, relief, housing, and so forth. In recent years, however, since these functions were incorporated into the functions of the Social Service Department, the case committee developed into an educational device to enable the Women's Auxiliary Board to carry out its function with a fuller understanding of patients' needs and of the requirements for sound professional services.

In 1954, a new director was faced with the need for changes and modifications in the functions of the department, based both on her own assessment and the results of a study already made of the department.[1] It became important, then, to acquaint the members of the auxiliary board with the implications of these findings, since they were the link both to the community and to the hospital's board of trustees. The case discussion method was already established as a successful method in working with

HELEN REHR, M.S., *is assistant director of the Social Service Department of the Mount Sinai Hospital of New York City.* *This paper is based on a talk delivered at the Fiftieth Anniversary of the Social Service Department at the hospital in October 1956.*

[1] Celia R. Moss, *Review of Structure, Organization and Function of the Social Service Department* (New York: The Mount Sinai Hospital, 1953).

the board [2] but its new use involved some specific and purposeful planning.

PRELIMINARY PLANNING

Informal discussion, on an unofficial level, with individual members of the board revealed a varying degree of understanding of casework function, a good appreciation of the medical setting for its fundamental purpose of treating the ill, but a more limited grasp of the skill and competence in the caseworker, and a minimal awareness of department structure. Since the department was analyzing each worker's performance as part of a study of possible job reassignments, it was decided to focus the case committee meetings on the question, "What is casework?" Then emphasis could be placed on the importance of professional training, the appropriateness of casework as a service in the medical setting, and the over-all department structure. Thus through explaining the "what" of practice, the "why" and "how" would be clarified.

The next step was to discuss these plans with key members of the board. The discussions were frank: we said we could foresee that some reallocation of service might be necessary; some personnel were untrained, and use of case aides might have to be considered; any changes would have to be considered in relation to the strengths of the department. At the same time, we emphasized that no major readjustments could be made without the agreement of the auxiliary since, as the community's "guardian," it was charged with interpreting new developments to the community. Following this a preliminary meeting of the case committee took place at which we discussed the various functions of the department, and the inappropriateness of some of them. Again, the role of the board was stressed as important and essential in paving the way for such changes as might be found necessary.

One member of the board was of invaluable assistance in helping to test out material for the group's reaction in advance. She helped in the selection of cases for presentation from those we brought to her, in determining the group's readiness for certain material, and in giving us specific suggestions about the presentation. For example, she cautioned us about using professional terms, and suggested that previously discussed material be reviewed briefly at the start of each case committee session. There was a difference between the lay and professional reaction—sometimes, we were oversensitive to possible reactions from the case committee; sometimes it was she who anticipated the group's overidentification with a given case.

PROPOSED METHOD

As already indicated, the case demonstration and discussion method was chosen because of its success in previous years. The cases to be presented to the committee first were relatively uncomplicated, and were chosen without regard to the medical service. For later sessions (no specific limit was set for the number of meetings required), more involved cases were selected. Regardless of the content or extent of the casework, each case demonstrated at least two casework concepts as well as some aspect of the medical setting.

These were the casework concepts we wanted to demonstrate:

1. The need for diagnostic astuteness in determining the inner strength of a patient, his relationships with members of his family, and the patient's true problem, either stated or unstated.

2. The importance of establishing the patient's trust in the worker and the significance of relationship as a tool in treatment.

3. The meaning of illness to a patient and the meaning to him of the medical setting.

4. The significance to a patient of taking help and some aspects of giving help.

[2] Jeanette R. Oppenheimer, "Staff Participation in Interpretation to a Lay Committee," *Medical Social Work*, Vol. 3, No. 3 (July 1954).

In discussing how help is given, we planned to describe:

1. Environmental manipulation, including preparation for a patient's transfer to another agency whenever it was indicated.
2. Help to the patient in developing insight into his problems.
3. The value and need for interpreting the patient's personality and social treatment to the medical and nursing disciplines.

In each case, the degree of skill required of the worker, how she defines a problem, and some of the casework methods she uses were shown. Emphasis was placed on casework practice, not on the specifics of any service such as giving relief or furnishing appliances.

In every discussion, time was allowed for questions from members of the auxiliary. We also expected that some cases would bring out community needs and the place for social action on the part of the Women's Auxiliary Board. Awareness of case material would inevitably call attention to program development for our own department, the hospital, and the community. Those aspects of over-all department structure needed to maintain competence and efficiency—for example, supervision, case aides, statistics, records, files—could be handled during the case discussions, but by this time it was planned that the groundwork for understanding casework would have been laid.

The educational supervisor selected the cases and worked with the other supervisors for suitable case material. We wanted cases that demonstrated skill on the part of the worker in making a diagnosis, in building a relationship with the patient, and in recognizing the importance of both timing and process. The educational supervisor also had the responsibility of presenting the cases, at least until the case committee and staff were comfortable with one another. Here are some of the cases used along with the questions and discussions they evoked from the committee members.

UNCOVERING THE REAL PROBLEM

One of the first cases demonstrated a service completed in one interview.

Mrs. A was referred to Social Service by the aide in the contraceptive clinic after she had mentioned her dissatisfaction with her husband's working hours. She was an alert, friendly, attractive 22-year-old who had given birth to a baby girl (her only child) eight months ago in this hospital. Her only contact in the hospital was with the contraceptive clinic. Mrs. A readily stated that her problem was her husband's night hours in his post office job, which she claimed was causing an upsetting change in their marital relationship since their schedules did not permit either one to enjoy normal living. Mr. A had tried to change his work shift on the basis of a medical recommendation, but his status as a substitute worker did not permit him this privilege. He worked from 11 P.M. to 8 A.M. When he arrived home, he was ready to sleep, and she and the baby were ready for activity. The interruption of his sleep in order to have lunch added to his annoyance and discomfort. He had an increased need for rest and this made him less available to the family. His increasing lack of interest in either Mrs. A or the baby had aroused her suspicion that her husband no longer loved her. She had accused him of this but he denied it.

The worker helped Mrs. A to express her feelings about his not being there when she needed and wanted him and what this meant to her. Mrs. A was able to say that perhaps he was jealous of the love and attention she gave the child almost to the point of excluding him. She reflected upon what she felt to be her extreme closeness to her own parents and siblings. It was possible that this was preventing her from adjusting maturely to her marriage and its accompanying responsibility. Even before the baby "perhaps" she had not really been close to Mr. A.

In this one contact Mrs. A responded well to the worker's interest. Since she

had the ability and willingness to discuss her problem, she was able to move toward recognizing her marital difficulties as involving more than her husband's working conditions. The sense that she also was contributing to the difficulty seemed to facilitate her desire to get help with her marital problem. The worker prepared her for referral to the family agency. She subsequently learned that the woman had initiated contact with that agency at which time they were apprised of the patient's physical well-being.

The discussion on this case revealed that many members of the group were able to see the need for quick appraisal of the situation, and the worker's ability to go directly to the core of the problem after testing out the patient's ability to seek help. They were interested that the problem posed was not the problem per se, and they could see the need for further help with the marital difficulty. Certain questions arose: "Could we change the husband's hours and why did we not attempt this as a first method?" "How do we sense there is more here than meets the eye?" "Why doesn't the worker continue since she seems to have made a good start with the patient?" "Why did we not make the actual referral for the patient to the other agency?" Time was spent in explaining the casework process from the point of request to the preparation for referral to another agency.

We pointed out to the group how the patient was referred to us and the value in the practice of returning to the referring source with an explanation of the outcome of our service. We showed the difference between this type of referral in which a clinic aide, although seeing the problem superficially, makes a referral for help with "working hours," and the kind of referral which frequently comes from a doctor in which he spells out his request for "convalescence, preventorium care for a child, nursing home," and so on. Although the doctor has the very best of intentions, these requests represent premature, social resolutions that do not take into account the patient's total situation. Frequently, a doctor offers these types of social solutions out of the framework of his own medical knowledge. However, it requires constant interpretation to doctors on the part of the social worker as to why preventorium care, nursing home, or convalescence may not be either the choice of the patient or the soundest solution in a given instance.

RAPID DIAGNOSIS AND SELF-DIRECTION

Two cases were usually presented in each session. In a later session one case turned out to be highly controversial and evoked a great deal of discussion. Two situations were selected for this particular meeting to demonstrate the worker's need to diagnose the patient's strength quickly and the patient's need to retain his sense of independence and to keep his self-respect.

Mrs. G, a 72-year-old unattached, moderately chronically ill woman, had been referred for more suitable living arrangements. The doctor had anticipated that her condition would become progressively worse and that she would eventually not be able to care for herself. Mrs. G had attempted to live in a home for the aged three years ago, but she had been unable to adjust. She learned how far the patient had come since the last attempted change and understood her anxiety about further change. She quickly learned that it had been the loss of the "familiar" for her in neighborhood friends, immediate surroundings, and so on, which had been most difficult for her to take. The worker, knowing Mrs. G's needs and right to arrive at her own planning, tested out plans with her and was able to get her to move step by step toward accepting a boarding home facility for herself. Because of the patient's physical limitations, the worker handled all the mechanical details and also interpreted the request to the public agency which was supporting her. That

agency was receptive to the plan of Mrs. G's locating her own facility which she eventually did.

The second situation of Mrs. S, a 76-year-old woman, limited by hip fracture, was referred because of the doctor's concern about her ability to manage.

> Mrs. S was an independent, self-managing woman whose family was interested in her and whose home condition was such as to permit continued management in spite of the physical limitation. The primary area of concern was the anxiety and sense of helplessness created as a result of the fracture. The worker helped her talk more about this and as Mrs. S improved physically she was able to help her regain her sense of her own strength and independence.

In the committee discussions we pointed out the worker's respect for a patient's independence by not taking over completely in either case and the self-direction permitted in the family of the second. We defined the meaning of the exploratory role of the social worker, the supportive aid given to a patient and her family, and the need to keep the doctor informed.

This latter situation seemed to touch off some mild fireworks by one member of the auxiliary who wondered what a social worker was doing in this case at all. She contended that an independent and able person did not need help. This session ended and the next one opened with discussion of some of the experiences of members with self-sufficient persons who faced crises. A number of them said that they had seen the impact of anxiety-creating situations on people they knew. They reported what happened when they offered friendly advice, and also mentioned situations showing the damaging effect on people when they had encouraged them in their helplessness. The concept of taking over the responsibilities of another person came very much to the fore in these discussions and with it an awareness of how fundamentally unreceptive people are to friendly advice. Committee members learned also from the discussion that each person reacts differently to crisis and that a solution for one would not be the solution for another.

ENABLING MOVEMENT

At another point considerable discussion was evoked by a case involving parents who had been referred by the doctor because of their hysteria and inability to give consent for an essential diagnostic procedure for their 2½-year-old who had been admitted for acute pneumonia and suspected tuberculosis. A one-interview process record was read aloud of the contact with the father whose wife was overcome by grief but who sat nearby.

> The worker began the contact by moving from the doctor's immediate request to get the father to see reason and accept the need for a bronchoscopy, to encouraging the father to tell her something of his family. Through this method she began to build a relationship with the man and to get some understanding of the excessive hysteria and immovability on the part of this couple at this time. She learned from him that they were a middle-aged couple who had their first and only child after twelve years of marriage. As she listened, she was able to help him to separate his intense and confused fear of the diagnosis of tuberculosis and the possibility of death from the use of the medical diagnostic tool itself. She relieved him enough so that he began to ask logical questions about the test and the child's medical course and then sent him back to the doctor for answers.

The major concern brought out by this case centered on a question from one of the members as to the adequacy and competence of the doctor. She thought that the doctor should have handled this type of problem. When the question was turned back to the group, the members were able to see what undue anxiety can be precipitated by a current episode which assumes

undue proportions because of its meanings in relation to past experiences. We were also able to point out that the caseworker in the medical setting needs to cut through heightened emotion in order to clarify a situation.

SUPPORT AND INSIGHT

By the fifth session, after consulting with our "liaison member," we decided to introduce the caseworker to the committee. A case from the Pediatric Service was selected to demonstrate intensive casework service with a divorced mother.

Mrs. M had been informed by the doctor that her 10-year-old child's condition was critical and would probably be fatal. The child had been studied medically for weeks and little other than palliative treatment could be offered. The referral had been made because this extremely intelligent woman had been unable to realize how ill her child was. She was driving the youngster to get well to the point where it was detrimental to the child's physical well-being. Also, her demands on the medical and nursing personnel were so extreme that the staff was showing marked antagonism to her.

The worker herself presented the case in an interview-by-interview fashion—revealing the support given the mother in her period of grief, the basic psychodynamics and personality of this woman. She also stressed the help given to Mrs. M in understanding her own attempts to control, and the importance of her considering herself and her well child. The worker also discussed the help given to the ward personnel in understanding the mother. The results of the casework process were very clear. Mrs. M exerted less pressure, the child was less tense, and the ward personnel were more accepting. The worker helped Mrs. M through her bereavement after the child's death and finally helped her to see the need for more intensive help for herself through psychiatric care which Mrs. M was able to accept.

This was one of those cases on which there was a difference of opinion between the auxiliary liaison member and ourselves as to how the committee would respond to certain types of situations. Although impressed with what had been accomplished with Mrs. M over a period of four months, she feared that many of the auxiliary members might overidentify with the case—they were themselves mothers and might put themselves in Mrs. M's place. Yet it had been decided to present the case.

Many questions about Mrs. M's personality were raised by the auxiliary but there was no evidence of overidentification. We used the case to re-emphasize concepts previously enlarged upon and which were in evidence here—the need for diagnostic awareness, the fact that the presenting problem is not necessarily the basic one, the need to determine inherent strength in a person, the worker's ability to focus on relieving inner pressures, and her skill which was essential in offering help to this woman.

During the entire series of cases presented, we discussed how much time was involved in the interview and how many were required for each case. Whenever possible, we introduced comments on the essential corollaries of interviewing; *e.g.*, casework supervision, privacy, record-keeping, case aides, statistics, and the like. During the balance of the series, workers brought their own cases and very fruitful discussions resulted.

NEED FOR FURTHER STUDY

One session toward the end of the series was devoted to what we called "frustration" cases in order to give a more realistic picture of the department's activities. One in particular revealed what could be done by an untrained worker with only limited skill and produced many pertinent questions. Clearly aware of the need for skill, the group asked why we could not transfer such a case to a more skilled worker. "What could supervision offer such a worker?"

Again, we discussed the importance of professional training for social work.

Another case presented at the same time was that of a skilled worker who could not help a woman to see her own needs. The woman continued to feel that she was a martyr and to externalize her problems. After many questions as to other possible approaches to this woman, committee members concluded for themselves that some people could not take help nor did they want it. We were able to show that timing was sometimes an important element in giving help. We also stressed that ours is still a growing profession and the methods of reaching people have not yet been fully realized. This point was illustrated with another case which suggested the need for continued study, exploration, and research of a variety of problems that face the profession and for which solutions have not yet been found.

The concluding session was an open discussion, in which we hoped to assess members' reactions to the year's program and to learn of their interests for the next year. In the committee's own evaluation of what they had gained, the members emphasized the importance of the worker's skill. The worker's timing in working with a patient was also seen as significant. They felt that they gained some idea of the scope of casework and of the over-all department practices. They expressed an interest in knowing more about the meaning and impact of the medical setting on casework practice and whether there were differences in casework practice in other settings such as family and children's agencies.

CONCLUSIONS

In reviewing the program, we arrived at a number of conclusions. In setting up a program for a lay committee, there needs to be a long-range plan within which there are also short-term goals. These short-term goals may shift from time to time, depending upon the way the program develops. Sometimes the details of a given plan cannot be adhered to rigidly and adjustments have to be made in the length of time allowed to achieve the short goal in the long-range plan.

The writer believes that it is primarily the responsibility of the professional worker to create interest in the casework service in the social service department, and in its structure. She must sustain that interest by continuously sharing with the lay leadership the changing concepts of service and function in the medical setting and in the social work field in general.

In working with a lay committee the purpose of meeting together must be clear. An auxiliary cannot be a rubber stamp for the professional program but must be a partner in its formulation. The director needs to give both old and new members an opportunity to learn about what they are supporting. The committee needs to develop an understanding of its dual responsibility to the department and to the community. If a lay committee is expected to respect professional skill, the professional must help it to recognize where professional competence is different from its own.

Before determining the content of program for a lay committee in relationship to a department's purpose, it is important to determine its orientation to casework and to assess the department. Assessment needs to go on in a continuing process coupled with knowledge of the staff's growing strength and the department's changing program. Moreover, a women's auxiliary board must have an understanding of the operation of a department in all its aspects —the work of the case aide, the untrained worker, the novice, and the experienced worker. As the lay group acquires this knowledge and background, the professional cannot remain static in her evaluation of the group, but must continue to help it develop further.

The professional worker needs to examine her own conviction of the soundness and value and meaning of lay partici-

pation and its place in the social work field. When she is convinced about the validity of such participation, she can use it creatively to enhance a department's program.

The case presentation method seemed to be most appropriate in accomplishing the objectives administratively set. As already outlined, these were to bring the Women's Auxiliary Board abreast of the newer developments in the field and to give them an understanding of professional skills so they might share constructively in any change or modification of the department's method. The case method offers a clear means of understanding the nuances of professional skill and the concept of movement and process. In a profession still developing its basic philosophy and its methods, it is a simple and appropriate means of translating these ideas. In time, when ours shall become a profession easy to distinguish from other helping services, other methods of interpretation may be more suitable. The case presentation method allows for discussion and offers an antidote to an overuse of professional language. In addition, it stimulates the worker to learn how to present material in nonprofessional terms, and is a natural method for a caseworker to use in working with a board toward their mutual objective—better service to the patient.

Many of the writer's colleagues feel that only an experienced worker should present cases. My experience is that any worker with sound training, regardless of the number of years of experience, can present case material if she is familiar with her setting. The key to sound presentation rests in the skill and security of supervision. With the support and encouragement of the supervisor, even a beginning worker can present material to a lay group.

We must remember that lay members have the right to raise questions. We must have faith in the group process and not be afraid of digression. In permitting free expression, we need to be adaptable to the content of that expression. A leader must be secure enough to be able to say when the occasion arises that the profession has yet to find answers to a particular problem. The presentation of cases when geared to a prescribed objective provides the opportunity for mutual learning between the professional worker and the layman.

PSYCHIATRIC SOCIAL WORK SECTION

BY IRVING WEISMAN

Impact of Setting upon Social Workers and Patients

IN A PSYCHIATRIC hospital setting, social workers generally attempt to understand the patient in terms of his needs, the nature of his illness, his recent and past history, and the like, and not particularly in relation to the setting in which the patient is encountered. The social sciences provide useful tools for examining settings as social structures which affect the behavior of their participants. Following this lead, this paper explores several commonly ignored facets of the impact of setting on worker and client. This is based on informal observation and not on the products of systematic research. Perhaps some additional viewpoints will emerge as a result that may broaden our understanding of patient and staff behavior and direct attention to further implications for treatment.

WHAT DO WE REALLY KNOW OF SETTING?

We are witnessing a renaissance of the relationship of social work and social science with illuminating contributions coming from social science to social work knowledge, theory, and research approaches. While some of this content is fairly well known to social workers, for example, that social structure is significant, the tendency is most often to proceed as if it were nonexistent. This tendency limits the effectiveness of social service within a hospital and the degree of participation in treatment. A recent study notes that chief social workers in psychiatric hospitals and clinics tended to minimize or to be unaware of the functions of social service beyond those closely related to direct social casework with patients and relatives.[1] Often we are rather narrowly focused on practice and service.

The Group for the Advancement of Psychiatry reports that social work has a place in the planning as well as the execution of hospital policy relating to the treatment and welfare of patients.[2] Implicitly, there seems to be an assumption that social work knowledge and a point of view concerning patient needs should have some impact upon the total hospital program. Social workers are generally quite con-

IRVING WEISMAN, M.S.S., *is lecturer in social casework at the New York School of Social Work, Columbia University.*

[1] Tessie D. Berkman, *Practice of Social Workers in Psychiatric Hospitals and Clinics* (New York: American Association of Psychiatric Social Workers, 1953), p. 15.

[2] *The Psychiatric Social Worker in a Psychiatric Hospital,* Report No. 2 (Topeka, Kan.: Group for the Advancement of Psychiatry, 1948), p. 2.

cerned and desire to contribute to the over-all program and relate to the "agency structure" which they then tend to perceive as a complicated series of departments and relationships, centering around the medical staff. It is then generally assumed that the way in which social workers develop their area of practice and how they may influence the total program depends on this series of delicate, interpersonal relationships with the various departments and disciplines represented. "The role of the psychiatric social worker in collaboration embraces understanding of the function of other team members and gradual deepening of understanding of the knowledge and skills which the psychiatrist, psychologist, social worker and others pool for study, diagnosis and treatment of patients. Development of a vocabulary by which to communicate, mutual assessment of skills, acceptance of the medical responsibility of the psychiatrist, are all components of a continuing, dynamic collaborative relationship." [3]

WHAT OF STATUS?

From the social sciences come a number of concepts regarding the nature of structure which generally are not given particular attention by social workers, *e.g.,* status systems. Little interest is devoted to how the basic organization of an institution automatically includes membership and a series of positions which are interconnected and interdependent social relationships in a social universe. Each position or "status" has responsibilities, obligations, duties, rights, and privileges in a hierarchy and has little to do with the personality of the individual occupying any given position. These are not functions of the individual. The pattern precedes the individual and persists after he is gone. It exists by virtue of position and not person. Based on our social work concept of the universal utility of the one-to-one relationship, we interpret status differences and conflicts as a function of relationship rather than as a structural phenomena. This interpretation brings about certain consequences for social work practice. When faced with broad problems of interdepartmental operation, we often assume that if only the hospital superintendent would depart, the total situation would be different with a new regime. Superintendents do retire, clinical directors are replaced, but hospital routines continue relatively undisturbed as part of an ongoing system.

A variety of status systems affect our functioning in a hospital setting. We encounter a professional status system which includes doctor, social worker, psychologist, nurse, aide, maintenance personnel, and others, roughly in this descending order. We encounter departmental status systems; *e.g.,* inpatient versus aftercare service, or admission service versus treatment service versus clinic services, or adult service versus children's services. This kind of ranking of services influences the selection and assignment of various kinds of personnel to the particular services. In turn, the quantity and quality of care offered is affected. Departments with inferior status generally are assigned minimal personnel of all types from psychiatric to recreational, and receive least in the way of research and administrative time.

We encounter also a personal status system which covers how individuals relate themselves to the director, clinical director, or department head. In many hospital settings, we can quickly determine the status of the social service unit by its physical location; that is, where it fits into the ecological arrangement of the hospital and the amount of space allocated. This determination provides what is usually an accurate assessment of how the social service department relates to the departmental status system and the professional status system, and is sometimes less related to particular administrative needs for space allo-

[3] *Teaching Psychiatric Social Work* (New York: American Association of Psychiatric Social Workers, 1955), p. 13.

cation or availability to hospital wards.

While hospital space within the fixed limits of the buildings is always at a premium, in many institutions the amount and the adequacy of the space assigned is indicative of status and prestige. We generally seek to have the social service offices located close to those of the director or the chief of service or the hub of hospital activity and to have space equivalent and equal at least to that of the medical personnel of lower rank. These may be appropriate objectives. When requests are made for shifts in the location of office space or curtailment of available space (*e.g.*, giving up a room), we are wont to perceive them as direct attacks upon the status of social service and attempts at down-grading. Since, as already suggested, the assigned space may be indicative of status and prestige, we are likely to resist such changes, with less concern for immediate reality needs of the total program and the possible legitimacy of the request.

In the psychiatric community we utilize another device for handling structural problems and formal relationships. We translate them into personal relationships in a diagnostic frame of reference which is more appropriately applicable to the patient group and generally unrelated to the problems at hand.[4] Often, when we are faced with a problem of subordination or frustration with a particular decision, we tend to deny or negate the status aspect of this with such rationales as: "It's because of his stage of analysis"; "He's mildly paranoid"; "He has problems in getting along with women." These rationales become almost a whole way of relating. By diagnosing feelings we may interpret every decision as an expression of someone's aggression without reference to the validity of the decision or the prerogatives and level of decision-making. This *modus operandi* becomes part of the language system of the psychiatric settting. An illustration of this kind of inappropriate response occurred in a training session in which a social worker raised a number of pertinent questions concerning some theoretical propositions that had been advanced which were difficult to illustrate. The response was, in effect, "If you have such resistance to understanding this proposition, you must have serious problems in this area and perhaps you need some treatment help." No attempt was made to explore or answer the questions raised. While this kind of gross distortion does not occur too often, the incident is cited as a dramatic example of what sometimes happens in interpreting everything in terms of personality and diagnosis.

THE PATIENT AND THE HOSPITAL SETTING

The twenty-four-hour-a-day living experience on the hospital ward has major effects upon all patients which are not necessarily related to the degree of illness or preexisting problems and relationships. The experience of this kind of group living precipitates the patient into a universe which is quite different from what he has known. We tend to respond to our patients as if their realities were the same as ours, or as if they went home at 5:00 P.M. as we do. We spend a good deal of time gathering data about the patients' social reality before coming to the hospital, but we then tend to know relatively little about the social reality of their experiences on the ward. The new situation all patients must face results from additional sets of requirements, including hospital regulations and practices, and the expectations of other patients.

EFFECTS OF HOSPITAL REGULATIONS

We start with the assumption that the patient needs hospital care and protection. To obtain such care the patient must participate in procedures and operations which often are less related to the patients' thera-

[4] Martin B. Loeb, "Some Dominant Cultural Scenes in a Psychiatric Hospital," *Social Problems* (July 1956).

peutic needs and possibly more related to the requirements of custody, hospital housekeeping, and administration. Some giving up of rights and responsibilities on becoming a patient is consistent with the definition of the patient role in our society, but in the extreme form that this takes, many institutional routines become almost ends in themselves and increasingly divorced from original objectives and patient needs. Without anticipation of the consequences, hospital routine removes all vestiges of decision-making from patients, not only those necessary to institute appropriate medical care, but many which, for therapeutic purposes, might best remain with the patient. Patient and staff are then deprived of possible additional avenues for therapeutic movement. This situation results neither from neglect nor poor planning, but rather as the unanticipated consequence of impersonal routine procedures.

As social workers, for the most part, we are quite unaware of the impact of routines upon patients except as individual crises intrude the routines into our consciousness. Sometimes we tend to interpret responses to hospital reality as signs of pathology, as when the patient who is frightened and bewildered fights against giving up his clothes and possessions. Is this an indication of his illness or part of a desperate attempt to defend and to hang onto some vestige of self-direction? It has been pointed out that what is often seen in the hospital as regression may be the result of hospitalization and not the process of disease.[5] Granting the need for observation and protection of the patient from being a danger to himself or others, do we know how much privacy he is permitted on the ward? In toileting? In bathing? Does dormitory living and routine management allow for choices of clothes and the frequency with which they may be changed? What is the frequency of bathing? The frequency of haircutting and shaving? What are eating and sleeping routines? Assuming the importance of fire regulations and precautions, how are smoking privileges handled? These are minor illustrations of some areas which, in normal living, are completely left to the choice or habit of the individual, but which, in the hospital, follow formal routines.

A study of patient attitudes toward hospital environment which confirms these impressions reported the greatest complaints against dormitory living. Admissions wards were described as terrifying by about 20 percent of the patients quizzed. The lack of privacy in toilet and bathing facilities was reported as a source of discomfort.

> An autocratic hospital system is inimical to the best interests of patients. Behind rigid rules and multifarious regulations lies the necessity for enforcement and obedience; this in turn tends to breed punitiveness and restrictiveness, and favors the drive in many individuals for power and control. Such a system cannot readily subordinate itself to individual differences or the manifold needs and demands of patients, which, when satisfied, yield ever more needs and demands. It is too often inflexible in the face of changing requirements of patients during various phases of their illness or recovery; of the changing culture within the hospital as treatment, research, and educational philosophy grow; and of modified demands from the outer community. Finally, such a system is not sufficiently self-critical to conduct experiments for the purpose of testing basic assumptions or evaluating ingrained procedure, and to integrate fundamental lessons from either experiment or experience into a growing social structure.[6]

[5] Walter E. Barton, "The Psychiatric Hospital As a Therapeutic Community," in Ruth I. Knee, ed., *Better Social Services for Mentally Ill Patients* (New York: American Association of Psychiatric Social Workers, 1955), p. 9.

[6] Milton Greenblatt, Richard H. York, and Esther L. Brown, *From Custodial to Therapeutic Patient Care in Mental Hospitals* (New York: Russell Sage Foundation, 1955), Chap. 6.

The material on social structure is presented to indicate some of the complexities we encounter in our daily work in institutions. It is not suggested that hospital structure is absolute and immutable. Operations which are dysfunctional for the patients must be identified and attempts made to alter them. For example, referral processes by which cases are funneled to social service are often largely based on individual and department relationships with medical staff members rather than on the former referral arrangements or specific patient needs. This may suggest that our hospital pattern of social services may be less responsive to patient needs than to staff relationships. Modifying the social structure of a hospital is no small task. Such systems tend to be self-maintaining and self-perpetuating with a resistance to change because of gratifications within the existing system and its values. No major change can be effected in any given area without consequences for the entire system. "How does one, then, go about modifying the hospital pattern, which is universally autocratic to open channels of communication, spread responsibility, increase participation, and foster initiative?" [7] Greenblatt and the others conclude that change may be effected by a formal redefinition of duties and responsibilities and the re-establishment of two-way communications. Stanton and Schwartz come to the same conclusion.[8] Scientific study may be used as a basis for initiating change. This may permit change in the formal organization.

One formal attempt to give more responsibility to patients was called "patient government." [9] Efforts at opening up communication between administration and patients resulted in patients taking on increasing responsibilities (beginning with convalescent patients) in housekeeping and organization of dormitory living. Meetings of patients with representatives of the administration and nursing, occupational therapy, social service, and psychological service were held regularly. Patients' government pointed out many physical needs (regarding supplies, damages, repairs), suggested activity and recreational programs, suggested some changes in treatment hours. They were allowed to raise and expend money; conduct tours for visitors; arrange evening snacks, and so forth. Therapeutic and administrative advantages accrued. Sometimes the institutionalization of a scientific investigation can be so designed that it allows and promotes change. To rely on a formal redefinition of function is an oversimplification of the problem since it assumes the interest and enthusiasm for change at all levels of staff involved. Thought must be given to who initiates change and an examination of the power structure involved. Attention must be directed to the readiness for change at top and middle administrative levels, and to how such readiness may be achieved. The entire problem of innovation and change in an ongoing hospital structure requires study and research and use of social science approaches.

From these observations, then, it appears that hospital experience presents a new universe to the patient with new patterns of behavior and new value systems to be learned. Seldom are staff members particularly involved or fully aware of these differences. We sometimes assume that the psychotic's behavior on the ward is random and only related to inner needs and tensions without recognizing that there are norms of behavior on the ward.

> . . . even a cursory examination of the hospital society demonstrates that patients on a ward are not merely an aggregate of individuals but are, in fact, a social group. Psychopathological be-

[7] Greenblatt *et al., ibid.*

[8] A. H. Stanton and M. S. Schwartz, *The Mental Hospital—A Study of Institutional Participation in Psychiatric Illness and Treatment* (New York: Basic Books, 1954).

[9] Greenblatt *et al., op. cit.*

> havior, usually conceived to be solely the expression of intrapsychic dynamics, is influenced, as a few recent investigators have shown, by interpersonal processes in a social field. The entire hospital structure, considered as a social system, exerts pronounced though little understood effects on the behavior of both patients and staff.[10]

The formal norms come from staff expectations and the informal norms come from what other patients expect in the way of patient behavior.

The role of the sick individual is one which generally exempts him from many of the usual responsibilities. Others take care of him. By institutional definition, he is not competent to care for himself. To begin with, he is to accept medical orders and let others in the environment make decisions, yet he has the obligation to get well. From the staff point of view, virtue on the ward is for the patient to submit and permit, conforming with the formal routines of patient management, including the patterns of eating, sleeping, wearing of clothes, and other patient activities as already described, including those specifically prescribed as treatment. In addition to the patterning of patient behavior that stems from the formal measures indicated, we must know more about what patients' attitudes are toward each other, toward treatment, toward the hospital, and toward illness. The patient group certainly creates a good deal of behavior by its expectations, which are relatively effective even on disturbed wards. It might be worthwhile to examine what the patient group's response is to excitement on the part of a given patient. Who generally handles outbursts? Are these outbursts sometimes patterned and are there prescribed conditions when verbal or physical excitement and aggression are permissible by the patient group and times and conditions when they are not? There is need for observation and study of this problem. For instance, in a particular hospital on the mess lines, at mealtime, particular patients were permitted by other patients and staff to be verbally aggressive. There were other times when patients quickly intervened, when it was deemed that the verbal aggression was inappropriate or directed at someone who should not be so addressed.

In general, the hospital patient group, like other groups, expects certain kinds of behavior and in exchange supports the individual patient's role and behavior, especially if it meets one of the needs of the group. Staff tends to focus on the meaning of patients' behavior in terms of the psychodynamic history of the individual patient with little attention or understanding given the informal group phenomena and differences in values which exist in the patient group. This important omission increases the cleavage and isolation between patients and staff.

No attempt has been made here to place any particular values, good or bad, upon the existence of bureaucratic hospital organization. Apparently social workers take for granted, rather than actually know, much of the patient's life experience in the hospital. This inquiry is not addressed to problems with a particular "bad attendant" or "bad doctor" or even "bad social worker" since all of these exist to varying degrees and in varying numbers, but rather to the broader situations of the everyday life of patients and staff in the institutional setting. In review, these considerations of setting seem broadly applicable to other kinds of institutions known to the author.

CONCLUSIONS

The concept of the hospital as a system of organization with a range of assigned positions and roles provides a useful approach to viewing some of the factors that impinge on treatment in a hospital setting.

Further study of hospital environment

[10] Edward Stainbrook, "Human Action in the Social System of the Psychiatric Hospital," in Knee, *op. cit.*, p. 19.

and its meaning for patients and staff merits attention since the setting appears markedly to affect the behavior of both. Formal hospital routine and informal patient groupings exert strong influence upon the patient, tending to pattern his behavior. How these pressures relate to his total behavior and his individual pathology requires careful examination.

Having reviewed some of the implications of hospital organizational structure, status systems, aspects of the hospital culture, and the effects of routinized living on patients, many questions arise for social workers. With these factors brought to our attention, what other ways of distributing our efforts become possible? Brief attention has been given to the problems of modifying dysfunctional aspects of the organizational structure. In the area of hospital routine and its meaning for patients, how may we participate in restructuring for support and restoration of self-esteem and health against deprivation and degradation? These are but a few of the emerging questions.

SCHOOL SOCIAL WORK SECTION

BY GRACE W. MITCHELL

Casework with the School Child

WHEN A CHILD has trouble in school, by and large he is unhappy about it. The school social worker brings him hope, and the comfort of being heard, and a heartening, healing draught of respect. The worker also evokes question, suspicion, and fear. The child senses a new conspiracy to overcome him and change him from without. The social worker yearns to let the child know how truly resolved he is (once he has helped the child perceive the richness of possibilities and the penalties risked) to leave with the child the right to choose his own goals and his own means.

He does tell the child that he is together with him—together with the part of the child that is troubled about his problem and longs to vanquish it; and that the school is together with them both and wants the child to have help. The school social worker knows he must say these things time and again, and that the child must also find them out for himself. However well the child has been prepared for the moment by someone important to him, the worker himself must somehow acknowledge with the child that this is an event which arouses not only hope and self-esteem but also fear and dislike.

STARTING SOUNDLY

The social worker tells who he is, why he comes to the school, how he helps children, how and why he works with parents, teacher, and administrator, what decisions belong to them and not to himself. He keeps in mind that the child is exploring him as busily as he is exploring the child—and more anxiously. They are finding each other, as persons and as partners.

The social worker tells some of the school troubles about which children come to him for help and gives the child a chance to say whether he has problems which worry him too. He and the worker weigh together whether his problems and what he wants to do about them are such that he could get help from the worker.

If the social worker tries to dodge what the problem is because it seems too delicate or too shameful or too complicated for a child to face, no help happens. If it is the child's problem, it cannot be solved unless it is solved with him and within him. A

GRACE W. MITCHELL, M.A., *is a visiting teacher in the department of guidance of the San Diego, California, public schools.*

new social worker who could not talk about stealing to a 7-year-old put their purpose merely on the basis of the boy's restlessness in class and friction on the playground. Nothing improved until finally the social worker summoned her courage and started, "Do you know why I have been seeing you?"

"No," said the boy in an unpent rush of words, "but I sure have been wondering." From that moment, helping moved swiftly and strongly.

Purposes that are talked about can become clearer, firmer. Feelings that can be talked about seem not so dreadful. Help that can be accepted or refused is no longer oppressive. Even if the child is made to come to the social worker (for some problems no one has a right to postpone), he cannot be made to use the help. The social worker should let the child know that he, too, understands this. For even if the child is made to come, casework skill can help him find his own goals for the coming.

Some children feel so defeated, so bare of worth, that they shrink from considering the problem as their own. It is the unreasonable school, their prejudiced playmates, their irascible brothers and sisters, even their misguided or defaulting parents that need modification, rather than they themselves. If conviction of hope begins to seep into their unhappiness, sometimes they can let life experiences teach them that there is something they themselves can do about their troubles. When the problem cannot be postponed, the social worker must bring this fact, this life experience, to them with sympathetic understanding and with unwavering firmness. Such children test the worker's patience of discernment and deftness of skill. Their need is not as slight as they would have others think. Their need is the greatest.

The social worker also offers appointments at a set time and place. Never having enough time, he must weigh in advance his commitment of it. Quality of an interview is more important than length. The time should be no longer than the child can use with purpose, and the child should have a share in deciding. An hour is too long for an elementary school child. Fifteen or twenty minutes can sometimes encompass intense achievement. If time is allowed to stretch out, there is danger that energy organized within a period of consistent effort may be thinned and dissipated. Or the fatigued child may lose control so that he tells too much and comes to distrust himself and the social worker and what they are doing together.

The social worker also gives the child an idea of the duration of time for which he is committing himself to try out this puzzling, enheartening, possibly dangerous kind of help. In setting a period when they will weigh together whether they wish or need to work together longer, school social workers can use the natural framework of school report periods, an advantage which they have over all other caseworkers. By setting such a period, the worker reveals his belief that something can be done even in the amount of time which can be comprehended by a school child; that the child is essentially able to handle his own life, even though he may need this interlude of assistance.

The school social worker and child look ahead to their next talk and select where they will start their thinking together. Perhaps they begin to lay out possible roads to solving the problem. The worker can estimate what the child will ultimately achieve. But he cannot determine it. However rational his expectation, the child may go far beyond it. However rational his expectation, the child may fall far short. The worker can determine only what he himself can do to help the child's task become more purposive and availing.

USING MANY LANGUAGES

The school social worker uses many languages in his work with the child. He listens to the language of the child's be-

havior, even as the child is listening to his. Both speak and hear in the language of posture, gesture, voice tone, muscle tautness, and the fleeting changes of the face. Art, music, or dancing may be a child's most comfortable and productive language. There is a language of touch; the child may sit close, take the worker's hand, want to feel the worker's palm on his shoulder. Or the child may not have learned to speak this language; or he may have learned to fear it.

If neither is afraid of silence, they can in their silences communicate large messages.

The rules of social intercourse have their language. The appointment broken without warning may say, "You were right; you cannot trust; you cannot trust even this help that is specifically for you." It may say, "You were right; your problems are not important. You are not important. And there is not much hope for you."

Play is a language of children, and a language which the adult social worker must learn as a foreigner. Therefore it has peculiar dangers. It can become an end in itself, consuming time, diffusing purposefulness, serving for little more than to gratify child and worker. Yet sometimes the child needs volunteered permission to play. It accords him the right of being a child. But play materials should always be very simple, not to distract from the business the child has with the caseworker. Far from imposing their use upon the child, the worker will count it a sign of progress when the child grows from the symbols of play to the more direct and confident symbols of words.

Most adults have not studied the language of play. The school social worker must make certain to let teacher and school administrator and parents and others know that what he and the child are doing together is not sport but painful exertion toward a goal; only the language is play.

When they commune in words, the worker will remember how hard it is to make words tell the full, brave truth. He will check the words, his own and the child's, by the other languages they are speaking.

The caseworker's most eloquent language is the total person he is. By using his conscious casework skills, with faith and fidelity and discipline and investment of his forces and relentless self-examination, he increases his total, and speaks with ever greater resonance and power.

For what does the worker use these languages? In the beginning and ending, he has many specific tasks to perform, but the principles of what he does in between are harder to put into words.

DISCOVERING PATTERNS

The school social worker helps the child face and claim his own patterns of feeling and acting, how he responds to life and people. He does this so that the child can begin to weigh where his patterns do and do not further the purposes which his heart values most. He helps the child know his ways not only through words but also through a sort of kinaesthesia of experience. The worker looks for words and acts which reveal the patterns ("I did not hit one kid this week"), and helps the child rest, for a fragment of time, with the meaning and feel it out as fully as he is ready to feel it ("You are letting me know that you have had trouble about hitting.").

The social worker looks, for full understanding, to how these patterns and feelings came into the child's life and what place they have in his scheme of living. But with the child he does not delve much into origins, knowing that it requires a psychiatrist's skill to reckon how vital to this particular child are the measures by which he protects himself from knowledge he cannot bear. The person who removes even one such device should know well what he is doing.

The child finds it a relief to talk of feelings to someone who understands the anxiety it is to have such feelings, who

does not hold the feelings against him. But the social worker understands also the anxiety and panic there can be in telling what is too dangerous, too much or too soon. If a child makes his revelations under the protection of drawing or make-believe, the worker is exceedingly cautious. He indicates only the outermost feeling tones, leaving the meanings guarded by symbols. If ever the worker lets a child confide too much, he knows the child will take home a deepening alarm. He knows that for several interviews to come the child may need spoken understanding about this alarm, and a patient pause for healing.

The social worker keeps the child attentive to the pattern which he and the child produce in the fabric of their working together. Through their heightened present, the child experiences and comprehends both the patterns he tends to follow and the flexibility and resources he possesses to create new patterns.

WINNING CLOSENESS TO AN ADULT

The child has known adults. He has found them to be supports, or comforts, or resources, or threats, or bosses, or weaklings, or strangers. He has built up imaginations about adults, and his imaginations may be fantastically inaccurate in terms of the parents and the teacher that he has. Sometimes, the social worker may long to cut himself off from being an adult. If he tries, it will be perplexing, harmful. But he can, as an adult, come close enough to the child for the child to perceive (and not too close for the child to perceive) a fuller image of grownups. Then the child can come to see that grownups may be weak but a resource; that they may be a threat and also a support; that they may be strangers, yet give comfort; that children need adults because adults know the rules, and without rules there is no safety.

The school social worker brings also a new and different image of adults. He and the child are alone together in an interview —not at the supper table, or in a classroom, or in a Scout meeting. The social worker is in a position to respond differently from any adult who takes an active, in-the-flesh part in the child's life with people. Parents, teachers, and group leaders can and often do try to like and encourage a child even while they dislike and vehemently discourage some of his behavior. But the social worker comes as an outsider who does not personally suffer for the misbehavior. In a new and unique way the worker separates the value of the child from the value of what he does. This adult opens to the child new and different avenues of interacting thought, interacting feeling, and interacting experience through which he can arrive at more harmonious relations with all adults and with all people.

Part of the child's new image of grownups (and of being grown up) is the social worker's disciplined response which turns steadfastly toward the child's feelings and needs and advantage. Part of the image is a new degree of trustworthiness. Troubled children have sometimes learned a bitter skepticism. They may even make agonizing efforts to prove that trust is always betrayed. They may do this for the strange reason that they want hungrily to prove beyond doubt that there *is* a trustworthiness which can never be broken down. To keep trust, the social worker will go over with the child truthfully what things can be said in confidence between them, what things the worker will tell the school and family so that each of them can stimulate one another to help him more. To keep trust, the worker will not pretend to know or understand what he does not know or understand. He will not offer hope that he can do what is not his to do. He will not give commendation which is insincere. As far as he can, he will be absolutely honest, absolutely faithful.

In his honesty he perceives in the child good as well as bad, bad as well as good. The child may have thought he was all bad, and lived as if he were. He may

have thought he had too much bad in him, and wanted people, wanted himself, not to catch so much as a glimpse of the terrible badness. The social worker dares to see both. By sensitive sharing of feeling, interacting back and forth, he gives the child not only information about himself, but courage to comprehend it. Suddenly the child does not have to exaggerate one way or the other. It is strengthening, he finds, to be able to live, even for a few minutes a week, with so much of the truth.

Moreover, he realizes that he has the respect and faith of this person who perceives a fair amount of the bad in him and a fair amount of the good—this person who sometimes surprises him by knowing his feelings so accurately, before he could have named them himself. Trusting this person, he can begin to hold himself a little higher, have a little faith that he can live with people in a way that he and they will like.

MARKING MILESTONES

Newborn faith will not be strong enough, seasoned faith will not be strong enough if the goal is perfection. Together child and social worker need to mark out next steps and near mileposts. They will lay out steps high enough for effort, not too high for faith.

Basic to the closeness between them is common belief that the child can, in the end, hard as it will be, reach the goals set, and that he will have in his struggle the aid of his parents and teacher and the social worker and others beside. The worker may need to remind the child (and teacher and parents and all) that growth in emotions and life patterns is slow and wavering, with many backslidings, with imperceptible ascents, with long plateaus, and that people do not grow in many directions at once. Together they will glance back at the beginning to get their bearings, and the social worker may ask gently, "How tall were you last year? You have grown and you hardly knew."

If progress continues to be small, they do not pretend. They look for a different way or choose a shorter step. Or they question whether casework is the answer. If there has been success, the caseworker helps the child savor it and measure the strength it has given for the next awaiting task.

Not always can they end with an onward tempo of hope for full emotional health. Once in a great while the social worker will think to himself, "Here there is nothing casework can accomplish; this child may always need to be overseen, brought to class, held to his lessons. Perhaps it is no longer possible for him to gain the power to direct his life." Sometimes the worker must be satisfied that they have slowed up deterioration, or merely held a perilous equilibrium.

"We haven't done much," said the school social worker sadly.

"We have too," the boy retorted, "I ain't no worse. The other kids went back to training school. I ain't no worse."

As they lay out the course ahead, the child needs to know not only his own patterns but the patterns and feelings of his world, and what these demand of him.

Children are still learning which ways are right, which are wrong. They seem to find many contradictions, and they may be particularly baffled by someone who likes them when they do things most people call bad, who lets them tell feelings they always thought to be bad. To help children enter into the society of their peers and their elders, to avoid confusing and hurting children, the school social worker has a special responsibility to interpret to them the standards of the school, which in the main are right for all children. And he upholds the authority of their parents. The school social worker is not loyal to the standards and expectations of school and parents because he is a fellow adult. He is loyal to school and parents because the child needs them so.

When a child wants right to be wrong and wrong to be right, to satisfy quickly

some need that is desperate and real, the social worker disciplines himself to maintain the truth about right and wrong. Tuned up as he is to keep that important togetherness which brings the child's feelings so close, the worker finds it no easy matter to hold himself so far apart from the child in his convictions. But helping the child escape through a false door, abetting his confusion, letting him define the world's expectations as less and poorer than they are—these are no services. They do not help a child surmount his real tasks, gain strength, and grow.

HELP FROM HOME, SCHOOL, CITY

The child is not solely responsible for his trouble. There are conditions in his family and sometimes in his neighborhood and school that have started, or precipitated, or enlarged his difficulties. The caseworker helps family and neighborhood and school, as he and they can, to change the conditions which still push the child into troublesome feelings and troublesome ways.

In any case, he does not involve himself in a child's school problems without the knowledge and consent of the child's parents. Usually he enlists the parents in the child's endeavor and becomes their ally too, in an auxiliary effort to fulfill more wisely and more heartily the opportunities of parenthood toward a child who is in trouble because he does not use his schooling well. It is the parents who provide the world in which a child lives most intensely, the world in which most of his feelings are born and take their shape. Sometimes the parents can construct a world where the child's new feelings, new patterns can find a better shape than did the old.

The school social worker also shares his growing understanding of the child's strengths and needs with the rest of the school in such a way as to enhance their desire and skill to aid the child. He helps the child find resources outside the school which can spur on and back up the improvements the child is making. He helps the child dare and decide to use all these.

GIVING AN ENDING

Casework, like college, terminates with commencement. It terminates at the point where administrator, teacher, parent, and the child himself think that the problem is on the road to being overcome and that they can carry on progress without the social worker. The social worker watches for emerging strengths which convince him that these people can carry on. He looks also for the edges of restlessness by which they indicate impatience to be about the the business of directing their affairs without unusual assistance. Once again the school social worker helps parents and child to see their pattern, this pattern of restlessness and the surging competence that underlies it. He helps them alight upon the idea of ending and return to it once and again until they can be comfortable with their own need and choice to be free of him.

An ending can fuse all that has gone before. Vast accomplishment can seem to happen suddenly. Indeed, sometimes when exertion has bogged down, a hint of premature ending ("We have done all we can unless you have more to offer, unless you want to do more") can step up the voltage of effort. Sometimes the social worker even makes an ending with the expectation of opening work again at a new level of meaning. What is lost, what is about to be lost, makes its preciousness felt.

Casework is an enterprise which demands depth of endeavor and intimacy of understanding. If its meaning is to last, the child should pause with the social worker for a backward look to see how things were at their beginning. He should tell or hear what has happened and what he has done to make it happen. The child may be able to face and tell things about his troubles, now that he has reached a tall milestone on the road out of them, that he could never face or tell before. He knows that

much of the solution and changing was his own accomplishment, that without his effort and pain no one could have accomplished it. By recapitulating how they achieved it, the child engineers a process design for future problems: how he can call on the skill and helpfulness of others; how he can count on capacity and determination within himself. He has new feelings about his inner resources and the resources for him in other people. And some of the resources, inner and outer, are ones that he did not have before. He has learned that he can work closely and truthfully with someone else. He has learned that the very working together, whether it succeeded or not—despite the pain it causes, despite the effort it demands—somehow satisfies a need, a deep need that was always within him.

It is hard to make a final ending at school, where child and social worker go in and out the same doors and greet the same people. It is hard not to use the habit of working together for endless daily decisions and for the false flares of difficulty which commonly spurt a time or two from the ashes of a long-burning trouble. It is hard for the social worker, who must watch and guard his own love of serving. Having earned the child's trust, he must now release the child to earn self-trust. He will leave time at the end for the child to test his powers to manage himself without the worker. He will leave time for the child to mull over his fears and the scared surprise of his successes. But he will let go, with confidence in the child, letting the child know and feel how confident he is.

Some children may be so appreciative of what the social worker has done to help that they are afraid to let him stop, and the first problem comes flooding back worse, it seems, than ever. But if the strength is there, and that restlessness which betrays the readiness to have done, the social worker will give them the ending they really wish and need. As both go on at school, passing in the halls and along playground paths, the worker will be pleased to watch the child's independence and stature increase until the transforming relationship they had and the momentous things they did together are lost and unrecalled in a vital, secure present.

Other children feel fewer complications about trusting their new strength, their new relationships. They move outward so smoothly that it is almost impolite. When this happens, the social worker does not feel discarded. For him it is a great reward.

The child knows that it is all right to have a problem, and that it was all right to come to this kind of person for help. The school social worker is confident that the child can manage his life. When a big enough problem comes again, if this problem becomes hard enough again, he can manage his life by seeking the same kind of working together. He would be wise to come then, and very welcome still.

POINTS AND VIEWPOINTS

Services for Children[1]

DURING THE PAST two decades the child care field has experienced dramatic changes reflecting the influences of socio-economic factors as well as the advancement in professional skills. Economic conditions have improved, health standards are better with resultant fewer deaths of parents, carefully screened intake and intensive undercare services have developed along with a growing awareness of the value of preventive services designed to keep the family intact.

The child in placement today is no longer the orphan of the old days, but the disturbed child placed because his behavior is so difficult that he cannot remain at home, because his home situation is too disturbing to permit his normal development—or because of a combination of these factors. As a result, the population in placement today has become by and large the residual and selected group representing the more disturbed families in the community. And the number of disturbed children continues to increase even as the number of children in placement decreases.

The community's increasing concern with this problem has given rise to new concepts and philosophies. These ideas must be carefully examined, however, before they are adopted and used all over the country without critical evaluation.

Basic to the establishment of a community program for these children is a clear understanding of the needs of the disturbed child through careful diagnostic facilities. There is still a tendency to think of care to the disturbed child, particularly the acting-out and aggressive one, in terms of placement away from home and in institutional facilities only. However, with more acute differential diagnostic appraisal, pointing to a broad continuum in the category of disturbed children, there should develop a wider variety of services for this group, both in placement and at home. The trend, however, has been to set up new, complicated, and expensive services despite the fact that many of these children not only require services different from those generally associated with the traditional child care agencies, but would, in addition, benefit considerably from enrichment of present services.

A community plan for services to the disturbed child must, therefore, include both provision for home care and foster care. Those disturbed children who can remain at home should have this opportunity through child guidance clinics, family counseling services, and lay treatment centers. When placement is indicated, we might think of at least four broad categories: (1) foster home care providing enriched services as well as special foster homes including group foster homes; (2) the educationally oriented group care facilities with a therapeutic milieu for the delinquent and/or aggressively disturbed children who do not require a closed environment; (3) psychiatrically oriented small group facilities utilizing education and casework as ancillary services for the more highly disturbed of the group; (4) the hospital ward for those requiring a closed environment.

[1] This is an excerpt from an address given at the New York State Welfare Conference in December 1956.

All too frequently, with the belief that the disturbed child can benefit only from the most highly specialized services now known as the "residential treatment centers," many communities have discounted their own resources and have abrogated their obligation to children in this group either by an inadequate referral or, more frequently, by placement away from the community, thus complicating integrated work with the family. The adoption of this concept of variegated services for the disturbed child by smaller communities which cannot establish expensive facilities will permit more of the disturbed children to be cared for within the local community. Separation by large distances should be undertaken *only* as a last resort and *only* for those children for whom alternative possibilities within their own communities have been considered and excluded.

We must also give consideration to the question of whether the disturbed children we now see can be served effectively, even with enriched programs, in large settings of one hundred and fifty to two hundred children. Can "treatment" go on beneficially at all "en masse"? We have come to accept the concept that function and structure should be interrelated. Is it not, therefore, desirable that with a change in function from an institution serving the "orphan" child to one serving the "highly disturbed" child, the structure be modified to insure the most effective operation?

WHAT IS A "RESIDENTIAL TREATMENT CENTER"?

Child care workers must be more discriminating in the use of the term "residential treatment center" which is appearing more and more in the literature of the field. On the one hand, the term applies to institutions serving large groups of children with a wide variety of personality problems, and on the other to smaller units serving twenty to twenty-five seriously disturbed children whose need is predominantly a psychiatric one. The differences between these services are significant and warrant a nomenclature that will not confuse the public (or the professional, either) about the services being rendered.

If, for the moment, the term "residential treatment center" is restricted to the highly specialized small units, a word of caution is needed with respect to the too rapid duplication of such units. There appears to be no agreement at the moment as to just what a residential treatment center is. The existing ones are new and there has been insufficient experience with them to warrant any conclusive findings. One does not yet know, for instance, the proper size of such units, the extent to which mingling of different types of disturbed children is feasible, nor indeed the real need if the full potentialities of special foster homes, day treatment units, or enriched programs in some of the existing facilities were fully explored. Further experimentation and co-operative evaluation should be undertaken before large capital investments are made for services which may be swiftly superseded.

It is essential, also, that we give serious consideration to a closer relationship between child care and family service agencies. The problem of placement has become more complicated, not only because of the nature of the families and children coming under care, but also because our new knowledge and skills have increased the responsibilities of agencies for the social and psychological rehabilitation of children and their families.

The more we examine the children and families who come to the placement agencies, the more we recognize that child care can no longer be considered in isolation, but must be viewed as a "family care" problem. Then the lines of demarcation between the responsibilities of the child care and family service agencies become more and more indistinguishable. The separation of function, with referrals to

other agencies, adds one more complication for the client and sets up artificial differentiations because of structures which have no counterpart in his life.

Too frequently in the past there was a tendency to live in an isolated atmosphere where the findings in family service were by and large offered to, used, and discussed by family workers, while the findings in child care similarly traveled the functional line. Now, with the development of common goals, it becomes clear that a greater degree of cross-fertilization is needed without necessarily obscuring the differences. It would be turning the clock back if we denied and lost the value of the specific skills that grew out of the period of specialization. Caseworkers now have reached that stage of maturity where it is not necessary to choose between the generic and the specific, but can apply both to the needs of the family.

In practice this means that the lines of communication among the several agencies in the field of casework must be thrown wide open so that when the findings in one field have a bearing on another, they will be available and used. Experience has indicated that the closer the structure, the easier this cross-fertilization. Merged child care and family agencies have demonstrated that these services can be offered, side by side, as a single entity, with such internal subdivisions as may be indicated. Multiservice agencies prevent duplicating services and provide a unique opportunity for an exchange of experiences and for mutual influence in the client's interest.

It is essential that we rethink the entire question of more effective use of our procedures and facilities, particularly in view of the sharp rise in per capita cost. Expenditures for services to children designed to build wholesome relationships may in the end be an economical investment for the community. Emotional advantages, of course, can never be calculated in monetary terms, but we must be sure that we are spending this money wisely.

We need to review critically such administrative procedures as scheduling interviews, length of interviews, recording, time spent in conferences, seminars, and so forth, to achieve more economical methods of operation. Greater flexibility in the selection of placement facilities will allow the more expensive type of services to be used only for those for whom there is clearly no other alternative solution. The need for more foster homes for an increasing number of children who are now referred to more costly institutional care may require modifications in procedures. We must recognize that, in seeking foster families to serve these children, we must make efforts to attract those willing and able to serve the present type of child, and above all, we must be prepared to pay for such service. We must continue to expand adoption possibilities. Further implied is the need to experiment continually with new ways of serving the children, for such endeavors may be less costly and may open up new vistas of professional service as well.

Hand in hand with improved services for children under care should come a further intensification of services to maintain family integration and to serve children in their own homes. This is obviously crucial in preventing breakdown of family life and in reducing the instances of child-family separation. Historically, these services have been the responsibility of the voluntary agencies and, by and large, still remain so. More recently, however, the participation of public agencies has been visible in increasing amounts as evidenced by the expansion of community mental health programs, organizations like the Youth Board, and special services to families in welfare centers sparked by federal appropriations. There still remains an imbalance between emphasis on cure and emphasis on prevention, and substantial expansion of preventive services should be a prerequisite for a sound community program in child care. All too frequently placements are arranged

by default because services that might have prevented family deterioration are not available in the community. It is incongruous to press for extension and enrichment of placement services without simultaneously concentrating on reducing those factors that precipitate placement.

The field urgently needs a continuing and intimate exchange of experience with the different types of services for this group in order to find guideposts for further development and before the present preferences become the established patterns of the future.

MARTHA K. SELIG
Federation of Jewish Philanthropies of New York

Clinical Is Generic

WE WHO PRACTICE in clinical settings—call us medical and psychiatric social workers, for yet a little while—have quite generally embraced the "Agreements on the Nature of Specialization in Social Work" issued by the Council on Social Work Education in the last two years. My own conceptual framework hardly creaked at all yesterday as I reread Ruth E. Smalley's *Specialization in Social Work Education*. Clinical social workers realize more clearly than ever how broadly generic our practice really is!

Unfortunately, our own past insistence upon our difference has hidden this fact from social workers in other fields: the fact that medical and psychiatric social work are just as generic as social work anywhere. At a recent NASW meeting I heard a young lady from a child-welfare agency say "But, if medical and psychiatric social workers have NASW Sections, why shouldn't *we caseworkers* have one too?" A day or two later, a student told me he couldn't decide "whether to specialize in medical social work, or in generic social work." These odd contradictions stem from a tenacious assumption by practitioners in single-discipline agencies (family, children's, public welfare) that their kind of setting is somehow primary, central, generic. Even educators sometimes speak of "generic agencies." Is there any reason, *sub specie aeternitatis,* why solo practice should be any more primary, central, or generic than teamwork practice?

The separate development of single-discipline practice (under agency auspices) and multidiscipline practice (through professional associations) emphasized the fact that fields of practice are all different, and obscured the fact that they are all more similar than different. As medical and psychiatric social work developed, they not only applied and tested generic principles; they not only learned and taught the specifics of their setting; they also made important contributions to the further growth of casework in general and of all social work. Grace White, in her article on "The Distinguishing Characteristics of Medical Social Work" in the September 1951 issue of *Medical Social Work,* clearly formulated the principles by which fields of practice, which are always specific, continuously feed and enrich the generic content of social work. As for the contributions of psychiatric social work, Florence Hollis says, "The need for thorough understanding of personality by workers in all fields is now widely recognized in contrast to the earlier assumption that this was important only for the caseworker practicing in a psychiatric setting."[1] What was once a specific of psychiatric social work has now become a generic of casework.

Most readers will probably accept these postulates: (1) that all settings provide both generic and specific content; (2) that some settings are "more generic" than others, in the sense that they prepare students or practitioners better for practice elsewhere; (3) that some settings are "more specific" than others, in the sense that effec-

[1] Florence Hollis, "Social Casework," in *Social Work Year Book 1957,* p. 528.

tive practice there requires more special learning rarely needed elsewhere; and (4) that one setting could logically be both more generic and more specific than another, in these senses.

If, then, we suppose that these differences can exist, surely we must go on to wonder how we might test, evaluate, and rank the agencies or settings in our universe. In my own efforts to grapple with this problem, I have considered and, alas, rejected several possible experiments. If, for example, the signs over the doors of the County Welfare Department and the County Probation Department were suddenly switched, would it not be tremendously worth while to see which agency could cope better with its new function and clientele? The discerning reader will unerringly point out serious flaws in this technique, and I can only reply that the other techniques I devised also had serious flaws. It might be possible to demonstrate that medical and psychiatric social workers actually have been accepted for employment in one-discipline agencies more often or more readily than the reverse; but even so, artificial one-way barriers might have regulated this flow unduly. On the whole, it seems best to turn the fact-finding aspects of this problem over to competent researchers (if they want it). I believe that given a high comparable level of administration and physical facilities, and given a high comparable level of education and experience among practitioners, these statements are true:

1. One casework setting is very nearly as good as another for "teaching generically," as regards the applicability elsewhere of the learning experiences they afford.

2. Medical and psychiatric settings are major resources for generic field-work experience, not just for the placement of students planning to practice in the clinical field.

3. Every field still requires, for the most effective practice, special learning experiences which are rarely needed elsewhere.

4. The difference between fields as regards the *amount* of special learning needed —and especially between the clinical field and other fields—is less than has been commonly supposed.

5. These special learning experiences require planned teaching, which must be done by the agency if not by the school, but might best be done by both together.

ROBERT W. CRUSER

Veterans Administration Hospital
Buffalo, New York

"Civil Defense Is Everybody's Business"

THE WORDS BELONG to FCDA's Administrator Peterson. They have been addressed to a variety of groups through the media of speaker's platform, press and radio; they have been converted into action through an operating agency with a staff of approximately eleven hundred persons, serving at national and regional levels. Their meaning probably varies for each group; the initial questions to which they give rise are most likely common to all groups—the traditional questions of "why" and "how." The answers should have particular significance for the 22,500 members of NASW who, irrespective of orientations or specializations, have a common meeting ground in their concern for the welfare of human beings and the protection of an established social order.

The "why" of civil defense as related to social workers is consolidated in the federal legislation by virtue of which the program exists; in the objectives of the program; in the planning assumptions which influence its operation. The "how" of civil defense, as it commands the attention of social workers, is identified with the human damage which accompanies nuclear attack; with welfare resources as instruments of counterattack; with professional skills as channels of service to persons.

Each of these questions is answered,

initially, in the Federal Civil Defense Act of 1950 (Public Law 920). Section 3b cites emergency welfare operations, shelter preparations, and evacuation plans as programs to be undertaken in the event of enemy attack, either actual or threatened. This means that, from the operational standpoint, social workers will be involved before, during, and after disaster strikes. Moreover, this involvement will of necessity extend far beyond such operations as supplying food, clothing, and shelter and into the highly charged areas of feeling and emotion. The extension is inevitable in view of the primary objective of the program covered by the law, *i.e.*, "to provide a plan of civil defense for the protection of life and property in the United States from attack." This plan aims, in part, to minimize the effects of such an attack upon the civilian population and to deal with the emergency conditions which disaster creates.

From the definitions included in Section 3, it becomes evident that the protection of human life and the restoration of essential facilities are the foci of all planning. Preparatory safety measures include recruitment and training of personnel, stockpiling, the provision of warning systems, the construction and preparation of shelters and shelter areas and "when appropriate the non-military evacuation of civil population." Restoration measures include rescue activities, emergency medical, health, and sanitation services, a welfare program which is to include—besides the provision of minimum housing, food, and clothing—such other services as are considered essential to the strength and morale of people suddenly deprived of a normal way of life. These services embrace, among others, help in reuniting families, financial assistance, and family counseling.

The reasons for such provisions are implicit in the planning assumptions formulated by FCDA in 1956. These assumptions represent an appraisal of available intelligence on the "known or estimated capabilities of potential aggressors" and are

intended as a basis for action in the event of attack. They rest on the premise that certain aggressors have the "technical and industrial capacity to wage full scale war" on the continental United States, using nuclear or conventional weapons. It is further assumed that, pending development of the intercontinental ballistic missile, "the major attack would be by air strokes with nuclear weapons." This means that preparatory measures must take into consideration the hazards of blast, heat, and radiation, both initial and residual. The conclusion is that enemy assault with thermonuclear weapons would "hit hard at this nation and its people and spread radioactive fallout over considerable areas."

The social work personnel of certain governmental units automatically becomes a part of the planning. Title II of Public Law 920 provides for delegation, to existing federal agencies, of "appropriate" civil defense responsibilities. Title III spells out the emergency powers by virtue of which any of these agencies "may be directed to provide personnel, materials and facilities" to the defense effort. Moreover, it gives the FCDA Administrator the power "to coordinate and direct, for civil defense purposes, the relief activities" of such agencies as well as to "provide financial assistance for the temporary relief or aid of any civilian injured or in want as the result of any attack."

In accordance with these provisions, the Department of Health, Education, and Welfare became the delegate agency responsible for the emergency programs of financial assistance and clothing. Over-all responsibility for the total welfare program, however, rests with the Welfare Officer of FCDA. As the functions of this office are extended to embrace a total program for the rehabilitation and recovery of the civilian population, the role of voluntary, as well as tax-supported, agencies will gain in importance. Planning agencies such as welfare councils should, for example, be ready to lead the way in furnishing much needed data on such questions as the organization of welfare resources and on manpower potential, both professional and lay. Direct service agencies should be prime agents in the planning and implementing of programs for the care of special groups—the unattached children, the aged and infirm, the physically and mentally handicapped whose problems will be appreciably intensified if community life is radically disrupted.

Social workers can lay claim to a particular competence in dealing with people under circumstances like these; they have a corresponding obligation to make that competence available whenever and wherever it is needed. The capability itself represents a combination of factors. It encompasses the ability to understand human responses to fear and trauma and suffering. It testifies to the social worker's knowledge and admiration of another person's capacity to meet and surmount difficulties and dangers. At one and the same time, it recognizes, and pays tribute to, the amazing capacity for self-help which is often revealed only when pressures seem unbearable. It emphasizes a readiness to work within the extent (or the limits) of that capacity in the hope, always, of doing something to restore the self-respect and self-determination without which human beings are no longer human.

By virtue of these qualifications, if for no other reason, the members of NASW should be cognizant of the current program of civil defense. They should experience a sense of obligation toward it, not because of the destructive forces which make civil defense planning necessary, but because of the constructive character of that planning as it is directed toward the preservation of social life and social order—planning that is truly "everybody's business."

MARY J. MCCORMICK

Federal Civil Defense Administrator
Battle Creek, Michigan

LETTERS

SIGNED: S.W.

I cannot resist writing to salute you for the challenging editorial in the January issue of SOCIAL WORK.

Your editorial combined with Marion Sanders' article in the current issue of *Harper's* magazine provide magnificent balance and stir one's whole being into action.

Here in Canada we are on the edge of really tackling the major issues you have raised.

CHARLES E. HENDRY, S.W.

University of Toronto
School of Social Work
Toronto, Canada

Thank you for your editorial in the April edition of SOCIAL WORK.

After eight years of administrative and supervisory experience in the children's field, a return to a practitioner's position in the field of working with older people almost left me "out" of NASW altogether. Some of us have wondered if we needed to start a Section and designate it as "general practitioners."

Your suggestion seems sound. It will probably be effected, too, if all of us become ready enough to belong to a sound profession.

ROBERT DE VRIES, S.W.

Home for Aged Lutherans
Wauwatosa, Wisconsin

Congratulations on last issue's editorial, whose form and content was a refreshing opener to an otherwise mediocre issue.

Heartfelt thanks is hereby given to the editor who is one of the few people in the field able to pin down her topic precisely instead of scattering the subject matter with a barrage of verbiage.

I agree with the proposal to combat the Family Service Association motion to organize a national certification program. This action by the FSAA would rob NASW of its rights and duties, and by any nationwide movement of this type without NASW will weaken the spindly structure of our new organization.

As a working substitute to forestall this, and as a first step to keep certification within the national association, let social workers designate themselves as such and place the initial "S.W." after their names. If enough of us do so, it will establish a precedent for forming a definition of practice when the time comes for national certification.

As a start let me sign myself.

JOHN J. RYAN, S.W.

New York, N. Y.

TOO MUCH SUPERVISION?

Instead of picking up various and sundry journals of social work and reading interminable articles on how to run a social service department in a hospital or a child guidance clinic with very little variation on the main theme, it is stimulating to see that some people are beginning to question some of the up-to-now, accepted-as-fact principles of supervision and the relationship that should exist between worker and supervisor. Some of us who have been practitioners for a goodly number of years have been walking around with tongue in cheek at what has been passing off as expert supervision.

Consider the supervisor who is highly thought of in an agency where, through a subtle but domineering manner, she controls workers and their case loads so they are not allowed the needed freedom for growth. In order to "adjust" they learn soon enough to assume a jellyfish clinging to the rock attitude and continue to be spoonfed with a mother-knows-best attitude for too long a period of time. It seems to

me that the purpose of all education is to teach people to think and to do so clearly and correctly. This important basic we hopefully pick up in our undergraduate education. Couple this with specific professional training in our chosen field, and add an intelligent and eager worker with proper attitudes and a willingness to further his specialized knowledge by taking courses and seminars and then ask yourself, "Why the same strong controls for so long a period of time?"

Can you imagine a group of lawyers, working for the same firm where the younger partners were not allowed to formulate and follow through on their own plans? Or a school principal who after a number of years has to check the daily lesson plans of teachers with five, ten, and fifteen years in the business? Granted one needs rather close supervision in the earlier years, but there must be a tapering off as one becomes more surefooted with practice. Consultation, yes; but stifling control, no.

Because of the prestige long associated with their role, too many supervisors are resting on their laurels and do not have their thinking caps on. What is needed is a great array of supervisors gifted with something called creative imagination. If supervisors learned to taper off the controls as required, they would have more free time to do some needed basic research and incidentally advance their own course. Too many agencies are filled with excellent case records crying out for research but in the meantime only collecting dust.

I was interested in Helen Harris Perlman's review in the April issue of Sidney Eisenberg's monograph on *Supervision in the Changing Field of Social Work*. She too sees the tendency to throw too much weight on discussion of the weaknesses of the caseworker to show the need for too much control. Isn't it time we examined the weaknesses of the supervisors and administrators?

MARY WALLACE

Casework Supervisor
Garden City, L. I., N. Y.